Chapter 1 BACKGROUND

Albania is a small country of about 28,748 km^2, situated in southeastern Europe. It borders on Greece to the south, the Former Yugoslav Republic of Macedonia to the east, the UN administered province of Kosova and Republic of Serbia and Montenegro to the north and the Adriatic and Ionian Seas to the west. There are 720 km of land borders and 362 km of coastline. The terrain is mountainous except along the central coast. About 42% of the 3.1 million people of Albania live in urban areas and approximately 20% of the population live in the capital of Tirana (INSTAT, 2002). Albanians are the majority ethnic group, representing over 95% of the population. Albania is a multi-religious country and three major religions, Muslim, Orthodox Christian, and Roman Catholic, have been important in contributing to the Albanian heritage and culture. All religious practice was outlawed and mosques and churches closed in 1967. However, private religious practice was again legalized in 1990, with a separation of religion and state functions.

There are no official data on the prevalence of religious identity among Albanians. A recent unofficial study indicated that about 72% of the country identifies themselves as Muslim, 18% as Orthodox Christian, and 10% as Roman Catholic (Neza, 2000), but religious affiliation is relative and linked mainly with inheritance from the past and not with current practice and beliefs.

Albania is administratively divided into 36 districts, 12 prefectures, 311 communes, and 64 municipalities (INSTAT, 2002). The population distribution between districts is quite different; there are districts with less than 10,000 inhabitants and there are districts with as many as 200,000 inhabitants. Seven cities with more than 50,000 inhabitants represent 62% of the total urban population. This diversity is reflected in the average number of persons per square kilometer. There are districts with as low as 21 persons per km^2 while there are a number of districts with more than 400 persons per km^2 (INSTAT, 2001).

The modern history of the Albanian state starts at the beginning of the last century when it gained independence from the Ottoman Empire in November 1912. Between the two world wars Albania was first a parliamentary democracy, then a monarchy. After the end of World War II, the National Liberation Front (NLF) led by the Communist Party, controlled the country and a one party system headed by the Workers' Party was established. At that time Albania was part of the socialist bloc but gradually became isolated not only from the capitalist West but from almost all other Communist countries. This isolation was complete after 1978 when the country broke ties with China.

The collapse of Communism across Eastern Europe in 1990–1991 brought a number of social, economic, and political changes to the region. Albania began a transition toward a democratic government and new, market-oriented economy, which has presented formidable challenges. The current Constitution of Albania was ratified in 1998 and established the government as a parliamentary republic, with the capital in Tirana.

During the past 12 years Albania has faced continuous political and social changes, and after a period of transition, interrupted many times by social crises such as those of the years 1991–1992 and 1997 (the collapse of pyramid schemes) and the Kosovo crisis in 1999, Albania is now a country undergoing profound economic and structural reforms.

The economy of the country is changing from a central economic planning system to a free-market system; many questions related to privatization, property ownership claims, and the appropriate regulation of business still remain unresolved. The country has experienced slow but steady economic progress; however, according to poverty baseline statistics, 25.4% of the population is poor and 5% of Albanian citizens live in extreme poverty. The rates of poverty are higher in rural and remote areas of the country (UNDP, 2004). The official unemployment rate is 16%, with two-thirds of all workers employed in agriculture, mostly at the subsistence level. Remittances from citizens working abroad remain extremely important, as does foreign assistance.

Albania is a lower middle income country with a Gross National Income (GNI) per capita of US$ 1,380. The agricultural sector accounts for 34% of Gross Domestic Product (GDP). Workers' remittances account for an additional 12% of GDP, with industry and services contributing 13% and 32%, respectively.

While economic growth in Albania has fluctuated during the last five years, it is now on a positive track for growth. The government is projecting that economic growth will increase to 6% from 2003-2005, with inflation rates of 2-4% (Ministry of Finance, 2002). The country has good potential for growth in agriculture, livestock, fisheries, forestry, tourism, mining, and light industry.

Nonetheless, the country faces considerable challenges as it remains one of the poorest countries in Europe. According to available data, as mentioned above, about one out of four Albanians is poor and lack access to basic services. A weak and deteriorating infrastructure and related services have left up to 40% of households without access to necessities such as basic education, water, sanitation, and heating. The Government of Albania has developed a National Strategy for Social and Economic Development (NSSED) to lower the level of poverty and improve social and economic development. The main objectives of the NSSED for the three-year period, 2002-2004, are the following: (i) real GDP growth of 22-25 percent; (ii) reduction of number of people living in poverty, particularly for the worst-affected social groups and areas; (iii) tangible improvement of infrastructure and related services, e.g. supply of potable water and electricity, particularly for the impoverished populations; (iv) reduction of infant and maternal mortality rates and disease incidence; and (v) increase in the level of elementary and secondary education school enrollment (Ministry of Finance, 2002).

Reductions in infant and maternal mortality are one of the objectives of the Strategy and it follows that the health sector is responsible for this objective. Public spending on health is low compared to the average of 3.0% of GDP for lower middle income countries. As a consequence, one of the strategic priorities for public expenditures is to increase the share of GDP allocated to the health sector. The government planned to increase the share of GDP in 2005 to 4% compared with 1.85% in 2001. The percentage of total public expenditures has increased to 11% in 2004 from 7.4% in 1998.

Albania started negotiations in January 2003 with the European Union for a Stabilization and Association Agreement (SAA). Negotiations have so far focused on political issues.

The Albanian Government committed to

achieve Millennium Development Goals (MDG) following the July 2003 parliament resolution in support of MDGs, and recently prepared a MDG Progress Report as a result of the work of national consensus building groups comprising all partners and stakeholders. The Albania relevant MDG targets and indicators have been identified at the national level and regional and local levels, adopting different regional strategies consistent with local and national indicators (UNDP 2004).

An Albanian-European Partnership Action Plan document has also been prepared by the Government with clearly identified measures to improve food safety, the environment and control and surveillance of communicable diseases, including process and outcome indicators. Also, the Government, in collaboration with donor agencies and other partners, is coordinating the MDG process and strategy using the objectives of the NSSED as well as related long term development efforts towards European and regional integration through the Stabilization and Association Agreement process. Strong links have been formed between global, national and local development agendas emphasizing national ownership of the process, unification of stakeholders and common advocacy campaigns, and establishing strong mechanisms for monitoring and reporting.

During the years 1992–1993 there was a huge wave of emigration, mainly to neighboring European countries (Greece and Italy). During the period 1990–1995, it is estimated that the number of emigrants fluctuated between 300,000 and 600,000, representing 9%–11% of the total population in 1995. Around 40% of them are estimated to be women and a new pattern of women emigrating alone without family members has been seen in recent years. Female trafficking and their exploitation as sex workers has appeared in the aftermath of the fall of old regime and in the vacuum of legislation (National Equity Committee, 2002; Lesko et al., 2003).

The social changes have also been associated with the internal migration of the population towards the big cities and particularly towards the capital city of Tirana. The internal migration during these years brought changes in the ratio of the urban/rural population. In 1989, the urban population was 36% of the total population and by the year 2001, the percentage had increased to 42% (INSTAT, 2002).

The demographic changes and the urbanization process are directly reflected in the decrease of the average household size. While in 1979 the average household size was 5.6 persons with 4.6 in the urban zones and 6.2 in the rural areas, the same indicator for 1989 was 4.7, 3.9, and 5.3 persons, respectively, and in the 2001 Census was 4.2, 3.9, and 4.5 persons, respectively (INSTAT, 2002). It appears that the tendency toward a family with two parents and two children is the new norm in Albania, as in many other countries. Internal migration has affected the lives of both women and children due to difficult access of services, unemployment and dependence on the male as the workers in the family.

Life expectancy for females in 2001 was estimated to be 77.5 compared with 72.5 for males. Women typically marry and begin families at a relatively young age; the average age at marriage for women is 23 years (INSTAT, 2002).

The provisions of the Albanian Constitution of 1946 sanctioned for the first time basic rights for women. However, Albanian women tend to follow a traditional model where women defer to the men in the family and the society has been very conservative

in preserving traditional family structures and inequalities in the family. The Albanian Parliament ratified in December 1993 the Convention on the Elimination of all Forms of Discrimination Against Women (AFPA et al, 2002). However, during the transition period, due to lack of work and high unemployment, women became more vulnerable and male or family support was necessary to survive. Many social services helping women in the past were eliminated due to lack of funding. In the northern parts of Albania the influence of the Kanun, a code of traditional law dating back several centuries, is still practiced although it was prohibited by the state after the second world war. In the aftermath of the fall of the hard-line Communist regime, the Kanun is reported to have regained strength in the north of the country (National Equity Committee, 2002). The Kanun declares a woman to be property transferable from her father to her husband.

When Albania was a Communist country, the healthcare system was centrally controlled and based on the Semashko model as in other countries of Eastern Europe and the Former Soviet Union. Health care was free to all with emphasis on infectious disease prevention and some health education programs, but an important percentage of the budget went to medical treatment. A variety of changes in the health legislation have been proposed very recently with the drafting or revision of important laws related to the financing and organization of the health care systems, and the creation of a health insurance fund and the patient rights card. Also, Albania has recently developed a new national ten-year strategy for healthcare reform. The implementation of a National Health Promotion Strategy has been discussed, consistent with the objectives of the health sector reform (under The National Strategy for Social-Economic Development) and includes the following goals: 1) increased effectiveness and efficiency in use of resources; 2) increased access to quality health services nationwide; and 3) improvement of health indicators through specific targeted interventions. The increased effectiveness and efficient use of resources will be achieved through: (i) improvement of the planning process and needs assessment with improved management and fairer distribution of resources; (ii) decentralization of management functions to local institutions, including regional health authorities, and strengthening of the role of professional organizations; (iii) reduction in corruption; (iv) the gradual establishment of information systems; and (v) support for the privatization process in providing health services and monitoring of the private sector (Ministry of Health, 2004)

The Primary Health Care Policy adopted in 1997 aims to offer accessible and financially affordable healthcare to all. Officially, health care still remains free, but while physicians are still employed by the state, many people pay for healthcare services in the form of gifts or unofficial fees for service. This unofficial expense comes out of limited household budgets. Very recently, user fees were introduced in hospitals and some primary health care facilities which are meant to limit and prevent "unofficial expenses." Even though many health care facilities were rehabilitated since 1997 there are still facilities that urgently need basic repairs. Also, due to the closed nature of the country until 1990, physicians may not have the most up-to-date information and skills. In addition to Ministry of Health operated clinics, there are now private providers of healthcare and clinics operated by international organizations.

Infant and under five mortality are officially reported as 23 deaths per 1,000 live births and 32 deaths per 1,000 live births, respectively, as of 2000, the

highest officially reported rate in Europe (INSTAT, 2002). Although these rates have both declined considerably from rates in the late 1950s and early 1960s, and the official statistics appear to show improvement in infant mortality since the transition, the rates may in fact be affected by problems such as non-registration of births in which the infant dies shortly thereafter and the definition of early neonatal deaths and early deaths of premature infants as stillbirths. Mortality rates are estimated to be more than twice as high among children in the more rural northern areas of the country than in the more urban central and coastal areas (World Bank, 1997).

For 50 years Albania had a pronatalist population policy; modern family planning was forbidden and it was taboo to speak about sexuality and contraception in public. Reproductive health care and basic family planning services were introduced into the country in 1992 after a Decision of the Council of the Ministers that declared family planning should be seen as a basic human right from which all citizens should be able to benefit on their own free will. Eleven services are now provided with three levels of care, starting with primary healthcare services (health centers, ambulances in villages, and consulting centers for women and children in cities), maternity and pediatric hospitals at the secondary level, and the Hospital of Obstetrics and Gynecology in Tirana and the University Hospital Center "Mother Teresa" in Tirana at the tertiary level of care. Also, national and international NGOs provide family planning services in addition to advocacy on this issue. However, women often have limited access to information and services regarding reproductive health, especially in rural areas.

Abortion, prior to 1991, was also forbidden and about half of the maternal deaths during the decade of the 1980's were due to complications following illegal abortion. In April 1991, through the "order of the Minister of Health" and the "Decision of the Council of Ministers for the approval of activities of Family Planning in Albania," abortion was legalized and modern methods of contraception were introduced in the public health services. The "Law for the Voluntary Interruption of Pregnancy until 12 Weeks Gestation" passed the Parliament in May 1995. Following its legalization in 1991, abortion declined as a cause of maternal mortality from 50% in 1989 to 25% in 1993 and to 6% in 1997 (unpublished paper, Population in Europe and North America on the Eve of the Millenium: Dynamic and Policy Responses, presented at the UNFPA Regional Population Meeting, December 1998, Budapest, Hungary). During the past 12 years, the figures for maternal and infant mortality remain relatively high despite the fact that they had declined by about 50% compared with the years before 1990.

A national law on reproductive health passed the parliament in June 2001 which regulates the management, administration, functioning and supervision of all reproductive health services and activities in public and private health institutions. The law protects the reproductive rights of individuals and couples in accordance with national policies and laws as well as known and accepted international principles. According to the law, the overall goals of reproductive healthcare services are to offer good access and quality reproductive healthcare; to improve the health status of women during their reproductive years, especially during childbearing and delivery; to improve the health status of newborns, infants, and children; and to improve the health of adolescents and young adults.

In addition to the striking similarities in socioeconomic conditions inherited from the Communist era, there have also been demographic and health similarities among countries in the region, in particular a heavy reliance on abortion rather than on modern contraception as a means of preventing unintended births. Therefore, reproductive health is an issue of critical importance for the countries of this region (CDC and ORC MACRO, 2004). Also, reproductive health has been considered as one of the priorities of the national health promotion and public health strategy (MOH, 2003)

Beginning in 1993, several surveys on family planning and reproductive health attitudes and behaviors were conducted in Eastern Europe (CDC and MACRO, 2003). To this end, the Division of Reproductive Health of the U.S. Centers for Disease Control and Prevention (CDC/DRH) in Atlanta has provided technical assistance for Reproductive Health Surveys (RHS) in collaboration with local counterparts. Between 1993 and 2001, ten Reproductive Health Surveys were conducted in seven countries in Eastern Europe.

A Reproductive Health Survey (RHS) was conducted in Albania in 2002 making it the 8th country in the region to conduct this type of survey. This survey represents the first systematic effort to gather representative national data on population and reproductive health issues in Albania. Population-based surveys of women of reproductive age using nationally representative samples are an effective mechanism for collecting information on topics such as family planning, fertility, contraceptive use, knowledge about HIV/AIDS, and other reproductive health issues. Until recently, relatively little detailed and reliable population-based information was available about the situation in the country with regard to important reproductive health topics.

The RHS, supported by USAID, UNFPA and UNICEF, examines patterns and levels of fertility, family planning, contraceptive use and method selection, health behaviors, knowledge of HIV/AIDS, as well as attitudes towards specific contraceptive methods and abortion. These issues are of particular importance in Albania, since for many years women and healthcare providers had limited access to up-to-date and reliable information on these topics. The survey also provides data on key maternal and child health indicators, infant feeding, and the extent to which mothers receive medical care during pregnancy and at delivery.

A principal objective of the survey is to examine the reproductive health status and needs that can be used to help direct or modify program interventions. These data are particularly useful in assisting policy makers and health planners in evaluating health service needs, and identifying reproductive health behaviors associated with poor health outcomes. They could also play a significant role in designing programs better targeted to meet the needs of population subgroups. A key programmatic difference between policy objectives in Albania and other countries in Eastern Europe, compared with those in some developing countries, is that the emphasis is not on promoting a decline in fertility and population growth, but on bringing about improvements in women's health through increased availability and improved use of modern contraceptive methods and reduced reliance on abortion. Until now, a comprehensive comparison of key family planning and reproductive

health indicators had never been compiled in Albania.

The nationally representative data on key indicators presented in this report can be used to design or modify health interventions, identify high-risk behaviors amenable to change and highlight reproductive health areas that warrant greater attention. These data can be translated into policy and programmatic activities to improve services and findings may be combined with other existing information to contribute to a more profound understanding of reproductive health in Albania.

CHAPTER 2 METHODOLOGY

Sampling Design

The Albania RHS 2002 is based on in-person, face-to-face interviews with 5,697 women and 1,740 men in their homes. The household-based survey was designed to collect information from a representative sample of men and women of reproductive age throughout Albania. Respondents were selected from the universe of all females aged 15–44 years and all males aged 15–49 years, regardless of marital status, who were living in Albania when the survey was conducted. Male and female samples were selected independently.

For analysis purposes, three strata were constructed for the sampling design: Metro Tirana, other urban areas and other rural areas. Metro Tirana includes 6 of the 19 communes in Tirana district: Bashkia Tirane (capital city of Tirana) , Kamez, Vore, Farke, Kashar and Paskuqan. These six communes include 85% of the District population and an estimated 92% of the urban population in the District. The "Other Urban Area" stratum includes urban areas outside of Metro Tirana and the "Other Rural Area" stratum includes all rural areas outside of Metro Tirana.

As in other countries in Eastern Europe with Reproductive Health Surveys, the survey had a three-stage sampling design, which allows independent estimates for the female and male samples. The first stage of the sample design was a selection of census sectors with probability proportional to the number of households recorded in the 2001 Census. During this stage, 300 census sectors, 100 in each of the strata defined above, were selected as primary sampling units (PSUs) throughout Albania. This step was accomplished by using a systematic sample with a random start in each strata for the female sample. A 33% sub-sample (every third PSU) of the census sectors selected in the female sample constituted the first stage of the male sample. Thus, the first-stage selection included 300 sectors for the female sample and 100 sectors for the male sample.

In the second stage of sampling, clusters of households were randomly selected in each PSU that was chosen in the first stage (separate households were selected for the female and male samples). Finally, in the third stage of sampling, in each of the households in the female sample, one woman aged 15–44 years was selected at random for interview and in the male sample one man aged 15–49 years was randomly selected for interview.

Metro Tirana and Other Urban Areas were over-sampled, and rural areas were under-sampled, so that more precise estimates could be made for the two mostly urban strata. Two variables are used in this report: STRATA, including metro Tirana, other urban areas and other rural areas as defined above and RESIDENCE representing urban or rural residence independent of strata. Urban residence includes the 100 PSUs in the "other urban areas" stratum and 86 of the 100 PSUs in Metro Tirana. Rural residence includes the 100 PSUs in the "other rural areas" stratum and 14 of the 100 sectors in Metro Tirana.

Some PSUs intended for both the male and female samples were not large enough to provide non–overlapping clusters. In these cases, an adjacent enumeration area in the same location was identified for the male sample, and in a few instances the male sample was drawn from a combination of both areas due to small population size.

Because only one respondent was selected from each household with women (or men) of reproductive age, all results have been weighted to compensate for the fact that some households included more than one eligible respondent. Survey results were also weighted to adjust for over-sampling of the metro Tirana stratum and other urban areas and under-sampling of rural areas. A review of the sample data compared with results from the 2001 census showed that there was differential non-response in certain age groups for both females and males and also differential non-response by marital status among females. Thus, a third weight was added to adjust for differential non-response. Response rates were lowest for unmarried women 30–44 years of age but they represent only 4% of all women of reproductive age (WRA). For women 15–19, married women were underrepresented and unmarried women overrepresented in the sample; however, married teenagers represent only 2% of all WRA. Thus, the differential non-response weight for females is not a significant adjustment. For males, teenagers 15–19 were over-represented in the sample and older working age men from 20–49 years of age slightly under-represented. The third weight for males adjusted for this differential non-response.

Presentation of Tables

All tables in this report represent weighted results. However, the un-weighted number of cases, used for variance estimates, is shown in each table (see Appendix A on sampling errors). Thus, the survey can be used to make national and sub-national estimates because of the process to "weight" the data —that is, to determine how many women in the population were represented by each woman in the sample.

Another note concerning data presented in tables in this report relates to percent distributions; although all percent distributions are shown to add to 100.0%, they may actually add to 99.9% or 100.1% due to rounding. Also tables for females (A) and males (B) that relate to the same topic are positioned to face each other for easier comparisons by the reader. Tables labeled A (female) will always be on an even-numbered page and corresponding B tables will be on the following odd-numbered page. To maintain these comparisons, there sometimes will be blank numbered pages in the table sections of the report.

Questionnaire

The individual questionnaire included information on each respondent's education, employment, living arrangements, and other background characteristics, as well as histories of marriage, divorce and cohabitation, sexual experience, pregnancy and contraceptive use. Additional questions investigated health risk behaviors that may affect reproductive health (smoking and drinking habits), women's health screening practices, young adult sexual and contraceptive behavior, knowledge and attitudes related to HIV/AIDS, and intimate partner violence. The questionnaire was developed in English and translated into Albanian and underwent two pretests. The second pretest, in May 2002, was performed to test changes in the questionnaire made after the first pretest.

Data Collection

The interviews were performed by 25 female and 8 male interviewers specially trained in interview techniques, survey procedures, and questionnaire content before the beginning of fieldwork. Interviewer training took place in the Health Authority Training Center, a facility next to the headquarters of the Albanian National Institute of Public Health (IPH), just before data collection began and consisted of one week of classroom

training in fieldwork procedures and proper administration of the questionnaire and one week of practical training in the field with close monitoring by the trainers. At the end of the training period, five female and two male teams were selected for the fieldwork. Each team consisted of one Supervisor, four Interviewers, and a Driver. Fieldwork was managed by staff of IPH with technical assistance from CDC/DRH. The overall fieldwork implementation was supervised by two fieldwork coordinators. Fieldwork lasted from August through December 2002. Each team was assigned to visit a number of primary sampling units in all regions of the country and traveled by car throughout the country on planned itineraries. Interviews were conducted at the homes of the respondents and lasted on average about 35 minutes for both men and women. Interviews were conducted in Albanian. Completed questionnaires were first reviewed in the field by team supervisors and then were taken by the fieldwork coordinators, who also reviewed them, to the National Institute for Statistics (INSTAT) headquarters where they were reviewed again by a data quality consultant before data processing.

Response Rates

Of the 10,316 households selected in the female household sample, 5,866 (57%) included at least one eligible woman (age 15–44 years) (Table 2.1A). One-third (34%) of households did not include an eligible woman and 8% of households were unoccupied, principally in rural areas (12%). Of the identified respondents, 5,697 were successfully interviewed, yielding an individual response rate of 97% for an overall response rate of 97% for women. Virtually all respondents who were selected to participate in the sample agreed to be interviewed and were very cooperative. Less than one percent refused to be interviewed. Response rates were similar in all three strata.

The male sample totaled 3,965 households with 1,831 (46%) including at least one eligible man (age 15–49 years) (Table 2.1B). A lower percentage of households included an eligible male than did the female sample (include an eligible female) due, in part, to the emigration of males of working age. A total of 1,740 eligible males were interviewed for a 95% individual response rate, yielding an overall response rate of 94% (.95 x 99%). As with the female sample, refusals were less than one percent and response rates in the three strata were similar.

Table 2.1 A
Results of Household Visits and Interview Status of Eligible Women by Stratum
(Percent Distribution)
Reproductive Health Survey: Albania 2002

		Strata		
Households Visits	**Total**	**Metro Tirana**	**Other Urban**	**Rural**
Identified eligible women*	56.9	59.7	52.5	58.6
No eligible woman lives in household	34.0	35.5	37.0	28.8
Residents not at home	0.8	0.3	1.4	0.6
Household refusal	0.0	0.0	0.0	0.0
Unoccupied house	8.4	4.5	9.1	12.0
Total	**100.0**	**100.0**	**100.0**	**100.0**
No. of Households Visited	**10,316**	**3,594**	**3,593**	**3,129**
Eligible Women				
Completed interview	97.1	98.2	96.3	96.7
Selected respondent not home	1.5	0.7	2.3	1.7
Selected respondent refusal	0.1	0.1	0.2	0.0
Other reasons**	0.2	0.4	0.2	0.0
Total	**100.0**	**100.0**	**100.0**	**100.0**
No. of Eligible Women Identified	**5,866**	**2,146**	**1,886**	**1,834**
No. of Completed Interviews	**5,697**	**2,108**	**1,816**	**1,773**

* Includes women 15–44 years of age who had complete or incomplete interviews, who were absent or handicapped, or who refused to be interviewed.

**Includes women with a handicap preventing them to be interviewed and women having incomplete interviews.

Table 2.1 B
Results of Household Visits and Interview Status of Eligible Men by Stratum (Percent Distribution)
Reproductive Health Survey: Albania 2002

		Strata		
Households Visits	**Total**	**Metro Tirana**	**Other Urban**	**Other Rural**
Identified eligible men*	46.2	54.3	42.2	41.2
No eligible man lives in household	42.0	34.7	45.5	46.5
Residents not at home	1.3	1.6	1.1	1.5
Household refusal	0.1	0.1	0.1	0.0
Unoccupied house	10.4	9.3	11.1	10.8
Total	**100.0**	**100.0**	**100.0**	**100.0**
No. of Households Visited	**3,965**	**1,402**	**1,380**	**1,183**
Eligible Men				
Completed interview	95.0	94.3	93.8	97.5
Selected respondent not home	4.4	4.3	6.2	2.5
Selected respondent refusal	0.2	0.5	0.0	0.0
Other reasons**	0.3	0.8	0.0	0.0
Total	100.0	100.0	100.0	100.0
No. of Eligible Men Identified	**1,831**	**761**	**583**	**487**
No. of Completed Interviews	**1,740**	**718**	**547**	**475**

* Includes men 15–49 years of age who had complete or incomplete interview, who were absent or handicapped, or who refused to be interviewed.

**Includes men with a handicap preventing them to be interviewed and men having incompleted interviews.

CHAPTER 3 CHARACTERISTICS OF THE SAMPLE

Household characteristics

In the 2002 Albania Reproductive Health Survey, the household questionnaire included a roster for the interviewer to list all members of the household who met the criteria to be eligible for the sample. From this list, one eligible respondent was randomly selected for the female sample or one eligible man was randomly selected for the male sample. The household questionnaire also listed the total number of persons living in the household. In addition, the individual questionnaire collected data on amenities and durable consumer goods belonging to the household, which would later be used to construct a socioeconomic scale to allow assignment of a socioeconomic status indicator to women and men in the sample. In this way, we would be able to examine the association of socioeconomic status with reproductive health indicators or behaviors measured in the survey. Tables 3.1 (A & B) and 3.2 (A & B) present data from the household questionnaire.

In Tables 3.1 (A & B), the average size of Albanian households can be seen to be 5.1 persons in the female sample and 4.6 persons in the male sample. The most frequent household sizes are four- and five-person households. More than half of all the households, for the total country and for specific geographic strata in both female and male samples, have an average size of four or five persons. Households of one or two persons are relatively rare, with less than 1% of households being single-person households and less than 4% being two-person households in both the female and male samples. However, the percentage of one- or two-person households may be understated due to the greater likelihood of the interviewer finding no one at home for the household interview visit compared to households having three or more members. As would be expected, rural areas have a slightly larger household size than urban areas, especially in the female sample.

Household amenities and consumer goods are shown in Tables 3.2A and 3.2B. Roughly one-quarter of Albanian households in 2002 had a telephone line, and 63% had flush toilets. Less than 10% had access to 24-hour electricity. Dramatic differences in these amenities can be seen between the urban and rural strata. This is particularly so for telephone lines and flush toilets. Almost half of the households in urban areas had telephone lines, whereas less than 10% of rural households had these lines. However, in both samples, approximately 60% of respondents (females-62%, males-58%) reported having cell phones; about two-thirds of households in urban areas and approximately half of households in rural areas. While more than three quarters of urban households had flush toilets, less than half of rural households reported having them. There is strong consistency between the female and male samples.

Among the durable goods possessed by households, the most frequent are TVs and refrigerators, with more than 90% of all households possessing these items. Ownership of these items appears to be geographically ubiquitous, with only minor differences between urban and rural areas. Seventy-eight percent of Albanian households have a gas or electric stove, roughly 60% have cell phones, and 21% have a working automobile. These three possessions vary markedly by strata, with their presence more common among the urban compared to the rural population. Computers and air-conditioning are rare. Less than 5% of households outside of Metro Tirana have these modern goods, and in Tirana only 12% of the households reported having them. Vegetable gardens,

on the other hand, are quite common, with 90% of rural households and 20 to 40% of urban households reporting access to a vegetable garden. Again, as with household amenities, there is strong consistency in percentages of durable goods between the female and male samples.

Characteristics of the Respondents

Tables 3.3A and 3.3B present selected sociodemographic characteristics of the samples.

Regarding the age distribution, 38% of female respondents and 33% of male respondents were young adults (15–24 years of age). The age distribution is slightly younger in rural areas for both females and males. Overall, the age distributions are similar to those found in official statistics (Instituti I Statistikes, 2002).

Sixty-five percent of women and 60% of men reported that they were currently married. Divorce and widowhood are very infrequent in Albania. Only 2% of women and less than 1% of men reported themselves in either of these categories. There is no significant urban-rural difference in marital status. More than a third of both women and men reported being childless, and among those with children, the modal number of children is two. Although the percentage of childless respondents did not significantly differ between urban and rural areas, more women and men reported three or more children in rural areas than in Tirana or other urban areas. Among women in rural areas, 28% had 3 or more children compared to 15% in Tirana and 16% in other urban areas. The corresponding percentages for men were 25% in rural areas, 13% in Tirana, and 11% in other urban areas.

Eight percent of women and 9% of men have had post-secondary education. Respondents in urban areas were significantly more likely to have post-secondary education than those in rural areas (17% vs. 2%). Most women (54%) and men (48%) have had only primary or no schooling. In rural areas, three-quarters of the female population and two-thirds of the male population fall into this latter category.

The majority of respondents reported that they were Muslim; 80% of women and 84% of men. This is somewhat higher than the 72% reported in the census, but this difference may be affected by differential emigration patterns. Another 8% of women and 9% of men said they were Orthodox, and Catholics made up 12% of the women and 4% of the men. Ethnically, the population is almost 100% Albanian.

As for religiosity — measured by frequency of attendance at religious services, less than 50% of respondents reported that they attend services at least once a month. The one exception to this norm is Catholic men living in rural areas. Among the latter group, two-thirds (67%) report they attend church once a month or more frequently. Otherwise, only 5% of all Muslim women and men report attending religious services at least once a month, and the comparable percentages for the other religions are 34% and 25% for Orthodox women and men, respectively, and 44% for Catholic women and 43% for Catholic men.

Only 49% of men and 15% of women reported that they were working outside the home for 20 or more hours per week. These percentages rise to 60% for men and 25% for women in urban areas, and drop to 39% for men and 8% for women in rural areas. As for geographic mobility, the women report more mobility than the men. More than half of the women (53%) reported to have ever migrated, with only 22% of the men reporting the same. As would be

expected, the Metro Tirana population has a much higher percentage of migrants than other urban or other rural places. Male-female differences in migration history are greatest in the rural population. Only 3% of rural men have ever migrated, whereas 51% of rural women report having migrated.

Tables 3.4A and 3.4B show the marital status distribution controlling for various sociodemographic characteristics. There is little to no variation in marital status by residence for both women and men. The positive association between age and marriage occurs before the age of 35 for both sexes, although women appear to marry at younger ages than men. By age 20–24, half of the women are married, whereas for men this proportion is not married until age 25–29. None of the men in the sample are married at ages 15–19, while 10% of women are married in these young ages. On the other hand, at ages 40–44, 4% of women and less than 1% of men have remained never married. The median age at first marriage is 21.9 years for the women and 26.5 years for the men (see Chapter 4).

An association for number of living children with marital status is observed only between no children and any children. Once there are any living children present, currently married status reaches 95% or higher. The relation of educational level with marital status appears to be linked in part with school attendance. Women and men with secondary incomplete and post-secondary educational levels are more likely to be still in school (data not shown) and, consequently, less likely to be married. For both sexes, those with completed secondary education are more likely to be married than those with primary or less. At the same time socioeconomic status has no effect for women and a very modest effect for men, with men at the lowest status level somewhat more likely to be married than those at the other two levels. Employed women and men have higher percentages married than those not working (74% vs. 64% for women and 76% vs. 45% for men), also likely reflecting current school attendance and young age among those not working.

Table 3.1 A
Size of Households with at Least One Eligible Respondent by Stratum
(Percent Distribution)
Female Sample,
Reproductive Health Survey: Albania 2002

	Strata			
No. Persons per Household	**Total**	**Tirana**	**Other Urban**	**Rural**
1	0.2	0.9	0.2	0.0
2	2.5	3.5	3.7	1.5
3	10.7	14.4	11.4	9.3
4	28.6	34.8	36.8	22.3
5	24.0	22.1	25.9	23.4
6	16.5	12.5	12.8	19.8
7	8.7	4.8	4.8	12.0
8 +	8.8	7.0	4.3	11.7
Total	100.0	100.0	100.0	100.0
Average No. of Persons	5.1	4.7	4.6	5.4
No. of Cases	5,788*	2,125	1,859	1,804

* Exludes 15 households whose number of inhabitants was unknown.

Table 3.1 B
Size of Households with at Least One Eligible Respondent by Stratum
(Percent Distribution)
Male Sample,
Reproductive Health Survey: Albania 2002

		Strata		
No. Persons Per Household	**Total**	**Metro Tirana**	**Other Urban**	**Other Rural**
1	0.5	0.9	0.7	0.2
2	3.9	5.3	4.6	2.9
3	14.4	15.6	19.7	10.8
4	30.8	32.1	40.3	24.6
5	27.4	21.9	24.1	31.4
6	12.6	13.2	8.2	15.0
7	6.7	6.0	2.0	9.7
8 +	3.8	4.9	0.3	5.4
Total	100.0	100.0	100.0	100.0
Average No. of Persons	4.6	4.6	4.1	4.9
No. of Cases	1825*	755	583	487

* Excludes 6 households whose number of inhabitants was unknown

Table 3.2 A
Percentage of Households with Basic Household Amenities and Goods, by Stratum, for Women Aged 15–44 Years
Reproductive Health Survey: Albania 2002

		Strata		
Household Amenities	**Total**	**Metro Tirana**	**Other Urban**	**Other Rural**
Flush Toilet	62.9	77.4	80.9	48.8
Cell Phone	61.6	69.5	66.5	56.7
Telephone Line	24.7	47.6	48.6	4.9
Electricity (24 Hours)	9.5	31.5	5.3	5.3
Vacation Home	1.5	5.6	1.1	0.5
Household Goods				
TV	96.4	97.7	98.5	94.9
Refrigerator	90.0	97.3	96.3	84.5
Gas/Electric Stove	78.1	84.0	93.7	67.9
Family Has Access to Vegetable Garden	60.7	33.9	22.9	89.0
VCR	31.8	44.6	42.4	22.3
Satellite Antenna	30.2	22.2	33.3	30.8
Auto	20.9	29.9	25.1	15.9
Computer	3.7	12.1	5.1	0.6
Air Conditioner	2.9	11.2	2.6	0.6
Percentage of Households With				
Crowded Conditions*	92.6	92.1	94.1	92.0
No. of Cases	5,697	2,108	1,816	1,773

* Total number of persons living in the household divided by total number rooms in the house (not including kitchen and bathroom) was higher than one

Table 3.2 B
Percentage of Households with Basic Household Amenities and Goods, by Stratum, for Men Aged 15–49 Years
Reproductive Health Survey: Albania 2002

		Strata		
Households Amenities	**Total**	**Metro Tirana**	**Other Urban**	**Other Rural**
Flush Toilet	62.9	83.2	76.5	46.9
Cell Phone	58.3	73.6	68.9	46.0
Telephone Line	24.0	46.8	39.9	5.6
Electricity (24 Hours)	5.3	19.2	3.3	1.1
Vacation Home	1.3	2.8	1.4	0.6
Household Goods				
TV	98.4	99.2	99.7	97.4
Refrigerator	92.7	98.4	98.7	86.9
Gas/Electric Stove	77.6	93.5	94.5	61.3
Family Has Access to Vegetable Garden	60.2	39.4	19.4	92.6
VCR	32.5	51.1	40.0	20.8
Auto	20.8	35.8	29.8	9.6
Satellite Antenna	17.3	18.7	16.1	17.5
Computer	3.9	12.7	4.1	0.4
Air Conditioner	3.2	12.2	2.2	0.3
Percentages of Households With				
Crowded Conditions*	88.5	86.9	87.6	89.6
No. of Cases	1,740	718	547	475

* Total number of persons living in the household divided by total number rooms in the house (not including kitchen and bathroom) was higher than one

Table 3.3 A
Percent Distribution of Characteristics of Female Sample by Residence and Stratum
Reproductive Health Survey: Albania 2002

		Residence		Strata		
Characteristics	**Total**	**Urban**	**Rural**	**Metro Tirana**	**Other Urban**	**Other Rural**
Age Group						
15–19	21.0	18.5	22.9	18.3	18.8	23.0
20–24	17.0	15.5	18.1	18.2	14.7	17.9
25–29	15.6	15.3	15.8	16.7	14.8	15.7
30–34	15.7	17.4	14.5	16.1	18.1	14.4
35–39	15.6	17.9	13.9	15.7	18.5	14.0
40–44	15.0	15.4	14.7	15.0	15.1	15.0
Marital Status						
Currently Married	65.1	66.3	64.2	63.1	68.0	64.1
Previously Married	2.1	2.4	1.8	2.9	2.1	1.9
Never Married	32.8	31.3	34.0	34.0	30.0	34.0
Living Children						
0	37.8	36.7	38.6	39.6	35.4	38.6
1	12.8	13.8	12.0	16.3	12.6	11.9
2	27.1	34.1	21.9	29.3	35.7	21.8
3	14.9	11.5	17.4	10.6	12.2	17.5
4 +	7.4	3.8	10.1	4.3	4.0	10.2
Education Level						
Primary or Less	53.9	27.5	73.7	33.8	27.7	74.0
Secondary Incomplete	10.2	14.3	7.2	12.0	15.1	7.1
Secondary Complete	27.7	41.3	17.6	35.9	42.3	17.4
Post-Secondary	8.1	16.8	1.6	18.2	14.9	1.5
Socioeconomic Index						
Low	42.2	20.0	58.8	22.1	21.4	59.4
Medium	49.5	63.0	39.5	53.9	66.6	39.0
High	8.2	17.0	1.7	24.0	12.0	1.6
Religion*						
Muslim	79.6	76.6	81.8	84.5	74.1	81.1
Orthodox	8.1	12.7	4.7	7.9	14.1	4.9
Catholic	11.5	9.2	13.2	5.7	10.7	13.6
Other/Undeclared	0.8	1.5	0.3	2.0	1.1	0.3
Employment						
Working	15.3	25.7	7.6	27.8	23.5	7.3
Not Working	84.7	74.3	92.4	72.2	76.5	92.7
Migration Status						
Ever Migrated	52.8	53.1	52.6	67.5	48.3	51.0
Never Migrated	47.0	46.7	47.3	31.7	51.7	48.9
Do Not Know	0.1	0.3	0.0	0.7	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	5,697	3,572	2,125	2,108	1,816	1,773

*With regard to religious service attendance, the percentages of women who attend religious services at least once a month are:

	Total	**Urban**	**Rural**	**Metro Tirana**	**Other Urban**	**Other Rural**
Muslim	5.4	6.5	4.6	6.3	6.7	4.5
Orthodox	33.7	34.9	31.2	37.3	34.2	31.3
Catholic	43.8	36.1	47.8	44.6	34.2	47.9

Table 3.3 B
Percent Distribution of Characteristics of Male Sample by Residence and Stratum
Reproductive Health Survey: Albania 2002

		Residence		Strata		
Characteristics	**Total**	**Urban**	**Rural**	**Metro Tirana**	**Other Urban**	**Other Rural**
Age Group						
15–19	18.9	16.6	20.9	16.3	16.9	21.0
20–24	14.5	13.2	15.6	14.9	13.3	15.0
25–29	13.3	12.9	13.7	14.2	12.0	13.8
30–34	13.6	14.6	12.8	12.4	15.8	12.8
35–39	14.1	14.6	13.7	11.7	16.3	13.8
40–44	14.2	15.6	12.9	16.2	14.8	13.0
45–49	11.4	12.4	10.6	14.3	11.0	10.6
Marital Status						
Married	60.3	59.6	61.0	59.8	59.8	60.9
Previously Married	0.6	0.9	0.4	1.2	0.5	0.4
Never Married	39.0	39.5	38.6	39.0	39.7	38.7
Living Children						
0	45.5	45.5	45.5	47.4	45.0	45.1
1	11.5	13.4	9.8	13.5	12.8	9.9
2	24.9	30.0	20.5	26.6	31.5	20.3
3	11.8	8.5	14.7	7.7	8.9	15.1
4 +	6.3	2.6	9.5	4.8	1.8	9.5
Education Level						
Primary or Less	48.4	28.4	65.7	30.0	30.5	66.1
Secondary Incomplete	8.7	10.6	7.1	11.8	9.7	6.9
Secondary Complete	33.9	43.6	25.5	39.6	44.4	25.4
Post-Secondary	9.1	17.4	1.8	18.7	15.4	1.6
Socioeconomic Index						
Low	47.2	25.1	66.4	20.9	29.2	68.2
Medium	42.2	53.6	32.3	52.3	54.8	30.9
High	10.6	21.3	1.2	26.8	16.0	1.0
Religion*						
Muslim	84.0	75.9	91.1	84.0	71.6	91.4
Orthodox	8.8	15.0	3.4	7.6	18.4	3.6
Catholic	4.3	5.6	3.1	3.4	7.3	2.8
Other/Undeclared	2.9	3.5	2.4	5.0	2.7	2.2
Employment						
Working	48.9	60.3	39.1	63.7	57.1	38.3
Not Working	51.1	39.7	60.9	36.3	42.9	61.7
Migration Status						
Ever Migrated	21.7	38.3	7.2	58.8	29.4	2.6
Never Migrated	78.1	61.2	92.7	39.8	70.6	97.4
Do Not Know	0.3	0.5	0.0	1.3	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	1,740	1,155	585	718	547	475

*With regard to religious service attendance, the percentages of men who attend religious services at least once a month are:

	Total	Urban	Rural	Metro Tirana	Other Urban	Other Rural
Muslim	5.4	3.1	7.2	4.9	2.8	6.9
Orthodox	25.0	23.6	30.5	23.0	23.7	30.5
Catholic	42.7	27.0	67.0	36.1	23.1	76.0

Table 3.4 A
Percent Distribution of Marital Status by Selected Characteristics, for Women Aged 15–44 Years
Reproductive Health Survey: Albania 2002

Characteristics	Marital Status			Total	No. of Cases
	Married	Previously Married	Never Married		
Total	65.1	2.1	32.8	100.0	5,697
Strata					
Metro Tirana	63.1	2.9	34.0	100.0	2,108
Other Urban	68.0	2.1	30.0	100.0	1,816
Other Rural	64.1	1.9	34.0	100.0	1,773
Residence					
Urban	66.3	2.4	31.3	100.0	3,572
Rural	64.2	1.8	34.0	100.0	2,125
Age Group					
15–19	9.5	0.0	90.5	100.0	1,094
20–24	49.5	0.3	50.2	100.0	936
25–29	78.9	2.8	18.3	100.0	946
30–34	89.5	1.8	8.6	100.0	1,067
35–39	92.3	3.9	3.8	100.0	958
40–44	92.5	4.6	2.8	100.0	696
Living Children					
0	12.9	0.3	86.8	100.0	1,943
1	94.8	5.2	0.0	100.0	828
2	96.9	3.1	0.0	100.0	1,840
3 +	97.9	2.1	0.0	100.0	1,086
Education Level					
Primary or Less	66.8	2.2	31.0	100.0	2,519
Secondary Incomplete	35.2	1.9	62.9	100.0	653
Secondary Complete	75.1	2.2	22.7	100.0	1,830
Post-Secondary	57.5	1.0	41.5	100.0	695
Socioeconomic Index					
Low	67.3	2.1	30.6	100.0	1,940
Medium	63.0	2.2	34.8	100.0	2,985
High	66.7	1.1	32.2	100.0	772
Employment					
Working	73.6	4.2	22.2	100.0	1,118
Not Working	63.6	1.7	34.7	100.0	4,579

Table 3.4 B
Percent Distribution of Marital Status by Selected Characteristics, for Men Aged 15–49 Years
Reproductive Health Survey: Albania 2002

Characteristics	Marital Status			Total	No. of Cases
	Married	Previously Married	Never Married		
Total	60.3	0.6	39.0	100.0	1740
Strata					
Metro Tirana	59.8	1.2	39.0	100.0	718
Other Urban	59.8	0.5	39.7	100.0	547
Other Rural	60.9	0.4	38.7	100.0	475
Residence					
Urban	59.6	0.9	39.5	100.0	1155
Rural	61.0	0.4	38.6	100.0	585
Age Group					
15–19	0.0	0.0	100.0	100.0	401
20–24	13.3	0.4	86.3	100.0	189
25–29	60.2	1.0	38.8	100.0	218
30–34	87.3	0.4	12.3	100.0	253
35–39	94.9	0.7	4.5	100.0	255
40–44	98.7	0.7	0.6	100.0	277
45–49	97.4	1.5	1.0	100.0	147
Living Children					
0	13.7	0.5	85.8	100.0	815
1	99.2	0.8	0.0	100.0	221
2	98.8	1.2	0.0	100.0	468
3 +	100.0	0.0	0.0	100.0	236
Education Level					
Primary or Less	60.9	0.6	38.5	100.0	689
Secondary Incomplete	13.9	0.3	85.9	100.0	199
Secondary Complete	72.1	0.6	27.2	100.0	626
Post-Secondary	58.0	0.8	41.2	100.0	226
Socioeconomic Index					
Low	63.6	0.5	35.9	100.0	638
Medium	57.4	0.5	42.1	100.0	814
High	57.3	1.8	40.8	100.0	288
Employment					
Working	75.9	0.8	23.3	100.0	913
Not Working	45.4	0.4	54.2	100.0	827

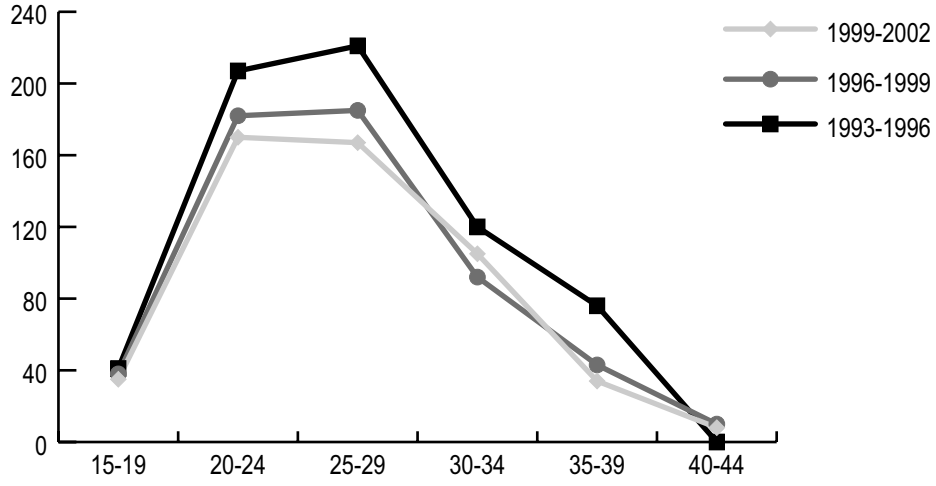
CHAPTER 4 FERTILITY AND PREGNANCY

Fertility Experience

Current levels of fertility presented in Tables 4.1, 4.2, 4.3A and 4.3B were estimated with the use of five-year age-specific fertility rates (ASFR) calculated from information collected through the respondents' lifetime pregnancy histories. ASFRs are expressed per 1000 women. The total fertility rate (TFR) is computed by multiplying the age-specific fertility rates by five (the number of years in each age group) and summing them over the reproductive ages. When this number is divided by 1000, the TFR can be defined as the average number of live births a women would have during her reproductive lifetime (15–44) if she experienced the observed ASFRs of a given time period. Numerators for the ASFRs were calculated by selecting live births that occurred during the 36-month period preceding the survey and grouping them (in five-year age groups) by the age of the mother at the time of the reported date of birth. The denominators for the rates represent the number of woman-years lived in each five-year age group during the specified three-year period.

Table 4.1 and Figure 4.1 present age-specific fertility rates calculated from the live birth history asked of every woman in the survey. These rates were calculated for three three-year periods over the last decade, 1993–1996, 1996–1999, and 1999–2002. As can be observed in the Table, the total fertility rate has declined substantially over the 10-year period, from 3.3 to 2.6 children per woman. This was due to pronounced declines in the most fertile ages of 20–24 and 25–29.

Figure 4.1
Three-Year Period Age-Specific Fertility Rates for Several Time Periods Among All Women



As with women in other countries of the region (Table 4.2), Albanian women initiate and complete childbearing at an early age. The highest fertility rates in Albania are among women 20–24 and 25–29 years of age, accounting for 33% and 32%, respectively, of the TFR of 2.6. Women aged 35–44 make a minimal contribution to total fertility of only 8% of the TFR. The adolescent fertility rate is very low, only 35 live births per 1000 women 15–19 years of age, representing 7% of the total fertility rate. The estimated TFR of 2.6 is a bit higher than the rate published by WHO for 2001 (2.4) and the rate of 2.3 published by the UN population Division (WHO, 2003; UN, 2003). The TFR of 2.6 is the highest in Europe and higher than the TFR in 9 of the 13 countries in Eastern Europe and the Former Soviet Union that have conducted similar Reproductive Health Surveys (CDC and MACRO, 2003).

There is no difference in the TFR in Albania by urban or rural residence, although the rate is slightly lower in Metropolitan Tirana than in the rest of the country (Table 4.3A). The TFR for women with a post-secondary education (2.0) is lower than the TFR for those with a primary (2.7) or secondary (2.5) education. Also, although the principal childbearing years for all women are 20–29 years of age, those with a post-secondary education tend to bear their children somewhat later at ages 25–34. There is also a tendency for age at childbearing to increase as SES increases.

Fertility rates for men are shown in Table 4.3B. These rates are based upon the responses of men to questions about children fathered by them. The male TFRs are universally lower than the female TFRs, due to very low fertility rates at ages 15–24 reflecting a later age at marriage and possibly indicating a tendency for men to underreport children fathered by them. Also, because of the smaller sample size for males with a small number of births reported by men, many of the male ASFRs are considered to be unstable. Nevertheless, the male rates show the same relationship with the selected characteristics as were observed for females in Table 4.3A. The male ASFRs also differ from the female in that they reveal older ages for childbearing, reflecting age differences between partners engaging in sexual intercourse.

Cumulative fertility of Albanian women and men is shown in Tables 4.4A and B. The number of live births (also known as "children ever born") in Table 4.4A shows that 38% of Albanian women in the reproductive years had not had a live birth at the time of the survey, but only 8% of women in union were without a live birth. By age 40–44, only 1% of married women reported never having had a live birth. The median number of live births for married women was 2, and for women at the end of their reproductive years the median increased to 3 live births.

Cumulative fertility levels observed for married men are similar to those of the women. Among all men, however, lower levels of fertility are reported, with 46% stating that they were childless. It is probable that single men are less knowledgeable about the number of children they may have fathered. It is worth noting that all men at ages 45–49 report completed fertility at similar levels to married women, most likely because most men in this age group are married.

Age at First Intercourse, Union and Birth

Tables 4.5A and B present data on age at first sexual intercourse, first union and first live birth for women and first sexual intercourse and first union for men, respectively, according to their age cohort at the time of the survey. By examining the percentages that have experienced sexual intercourse or marriage or a live birth by current age cohort, it is possible to determine whether the ages at which these events first take place are changing over time. For example, in Table 4.5A, the percentage of women who experienced sexual intercourse before age 18 increased from 10% among current 40–44 year olds to 16% among current 20–24 year olds. Similarly, the percentage of 40–44 year olds who married before age 18 is 7%, whereas 11% of 20–24 year olds married before age 18. In turn, a higher percentage of first live births before age 18 and before age 20 result from the younger ages of first intercourse and first union. Of course, these data cannot reveal the temporal relationship between marriage and intercourse – that is, which of these events preceded the other. It is also important to note that less than half of the women had had intercourse (47%) or had been married (41%) before age 22 and only a quarter had had a live birth (26%) before reaching 22 years of age. These findings are reflected in an average age 21.1 years at first intercourse, 21.9 years at first marriage, and 23.4 years at first live birth. These averages show little change across the age cohorts, suggesting little change over the last two decades in the timing of these events in a woman's life cycle.

Data for the men are shown in Table 4.5B. Here we see a more dramatic change in age at first intercourse across time. Only 5% of men currently aged 45–49 reported having had first sexual intercourse before age 18, compared to 22% of men currently aged 20–24. This substantial increase is also seen for percentages that had first intercourse by the age of 20. However, these increases in sexual experience at younger ages are not reflected in the average age at first intercourse for all ages and cohorts, which remained relatively stable over time. Also, age at first sexual intercourse for men does not correspond as closely to age at first marriage as it does for women. Thus, while the median age at first intercourse for all men is 21.5 years, the median age at first marriage for men is 26.5 years.

When observed by residence (Table 4.6), age at first intercourse for women is rather stable. The median age at first intercourse does not vary between urban and rural areas. However, on average, women in urban areas marry and have their first births a year later than those in rural areas. Educational level shows an even stronger and consistent effect on ages of these three events, resulting in a three-year difference in average age at first intercourse (20.5 vs. 23.3), a four-year difference in age at first marriage (21.0 vs. 25.1) and a four-year difference in age at first birth (22.5 vs. 26.6), when comparing the lowest and highest educational categories. (See also Figure 4.2.)

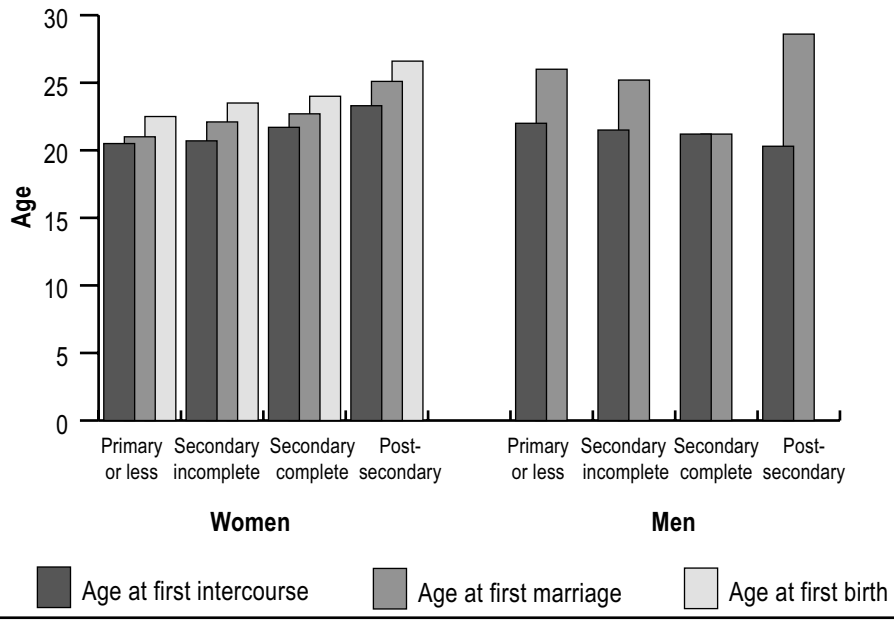
The patterns of age at first intercourse for men are somewhat different from those of women (Table 4.6). In contrast to women, the average age at first intercourse for men is higher in rural areas and inversely affected by educational level. For men in rural areas, the median age at first intercourse is 22.2 years compared to 20.6 years for men in urban areas. Likewise,

men with primary or lower levels of education have a median age of 22.0 years at first intercourse compared to 20.3 years for men with post-secondary education. Urbanization and education have the opposite effect on age at marriage for men. The median age at first marriage increases from 25.8 years for men living in rural areas to 27.4 years for those residing in urban areas. Similarly, men with the lowest educational levels marry, on average, at 26.0 years of age compared to 28.6 years of age for men with the highest level of education. The education effects for men are shown also in Figure 4.2.

Current Sexual Activity

Current sexual activity is an important measure for determining the women who are risk of an unintended pregnancy and thus in need of contraceptive services. Table 4.7 shows that 70% of Albanian women in their reproductive years have had sexual intercourse. This percentage comprises all married and previously married women and 8% of never married women. Seventy-five percent of currently married women had intercourse within the last month, and another 13% had last intercourse 1–3 months prior to the survey. Another 7% reported a pregnancy-related reason for no current sexual activity. Among previously married women, 76% last had intercourse one or more years ago, presumably when they were still married. Almost half (48%) of the sexually experienced never married women have had intercourse within the last month (3.9%/8.2%) and another 23% had their last intercourse 1–3 months ago (1.9%/8.2%). Current sexual activity among men is higher than that of women. Seventy-six percent of all men have ever had sexual intercourse, including 38% of never married men. The percentage of men who had

Figure 4.2
Median Age at First Sexual Intercourse, First Marriage and First Birth by Education Level



intercourse in the last month was 83% of the currently married and 14% of the never married men. Among the sexually experienced never married men, 38% (14.4%/37.5%) had sex in the last month and another 29% (11.0%/37.5%) had sex 1–3 months prior to the survey.

Induced Abortion

For several decades one of the most outstanding demographic features of most of the Eastern European countries has been the high reliance on induced abortion as a means of birth prevention (David, 1992). Induced abortion was the single most important means of controlling fertility. In recent years, abortion rates and ratios in many of these countries have been among the highest in the world. Among the factors frequently cited as contributing to the reliance on abortion has been the limited availability of modern contraceptive methods, poor quality of methods available, fears about possible side effects, and easy access to and low cost of induced abortion. However, since 1990, data show that an increase in use of modern contraception has been associated with a decline in abortion in many countries of the region (C Westoff et al., 1998, 2000, 2002; CDC and MACRO, 2003).

As with the calculation of the total fertility rate, age-specific induced abortion rates are calculated by using the age of the woman at age of pregnancy termination and then summed over the ages 15–44 to produce a total abortion rate. In Table 4.8, the number of induced abortions per 1000 live births reported in the reproductive health survey for the three years prior to the survey is compared with the official data reported to the Institute of Statistics (INSTAT) for 1999–2001. The survey rate of 73 abortions per 1,000 live births is 64% lower than the official data of 200 per 1,000 live births (three-year average) reported to INSTAT. Over the last three-year period, the official ratio reported to INSTAT has declined from 241 per 1,000 live births to 172 per 1,000, a 29% decrease (Instituti I Statistikes, 2003).

In Romania and the countries of the Former Soviet Union that have conducted Reproductive Health Surveys or Demographic and Health Surveys, reporting of induced abortion by survey respondents has been close to, and in some cases, has exceeded official reporting. (CDC and MACRO, 2003). Only in the Czech Republic has there been severe under-reporting of induced abortion by respondents as appears to be the case in Albania. It is estimated that respondents in the Czech survey only reported between 45% and 50% of induced abortions they underwent (Czech Statistical Office et al., 1995).

There are three principal factors that may affect the under-reporting of induced abortions, even in a country where they are legal, by survey respondents: (1) Under-reporting of unwanted pregnancies that have a higher probability of being terminated by the voluntary interruption of the pregnancy (see next section of this chapter); (2) Under-reporting of clandestine abortions outside of the medical system; and (3) a tendency to declare induced abortion as spontaneous abortions or miscarriages (see next section of this chapter).

Since the apparent underreporting of abortion by survey respondents is at least 50% and may be as high as 77%, and since the underreporting is most likely not a random event but associated with characteristics of the respondent, data from the survey on abortion is probably unreliable. For this reason, the further analysis of abortion data is considered beyond the scope of this report.

Planning Status of the Last Pregnancy

For every pregnancy ended since January 1997, respondents were asked the planning status of their pregnancies at the time of conception. Each pregnancy was classified as either intended (wanted at the time it occurred), mistimed (occurring earlier than intended), unwanted (the respondent did not want any more children), or the respondent was unsure. Mistimed and unwanted pregnancies together constitute unintended pregnancies (Westoff, 1976).

Despite the under-reporting of induced abortions, strongly associated with unwanted pregnancies, the results in Table 4.9A are somewhat useful for examining relative levels of the planning status of the last pregnancy among the various population sub-groups. The sharp differential between pregnancies ending in induced abortion and a live birth (or a current pregnancy) is obvious. Almost two-thirds (65%) of pregnancies ending in induced abortion were reported as unwanted compared with only 3% of current pregnancies and live births. Also, 11% of pregnancies ending in stillbirth, spontaneous abortion, or an ectopic pregnancy, were reported as unwanted, although the proportion would not be expected to be significantly higher than the 3% of live births reported as unwanted. This suggests that some women who experienced an induced abortion reported their pregnancy outcome as a spontaneous abortion.

The proportion of unwanted pregnancies increases as age group and number of living children, two correlated variables, increase, reaching 20% for 35–44 year old women and 28% for women with four or more living children. Mistimed pregnancies are highest for young adults 15–24 years of age and women with no living children. No major differences are seen by residence or by education. A rough adjustment for the underreporting of abortions puts the percentage of unwanted pregnancies closer to 12% (one out every eight pregnancies) compared with the 7% shown in the table.

Among men, for whom there is no pregnancy data, Table 4.9B shows men reporting 98% of last live births as intended, with no differentials observed by residence, age, number of living children or educational level.

Future Fertility Preferences

Data on fertility preferences are needed so that a determination can be made of the appropriate forms of contraception required by couples in the society. Tables 4.10A and B present future fertility preferences of currently married women and men. Approximately two-thirds (63%) of married women want no more children (Table 4.10A). Another 12% want a child after two or more years. The desire for no more children increases with parity from 2% of married women with no living children to 92% of women who have four or more children. The desire to delay the next birth for two years or longer is highest (45%) among women with one child. Age shows the same direct relationship with wanting no more children as observed for parity, with a low of 5% among women 15–19 and a high of 90% among women 40–44 years of age. Wanting to postpone the birth of a child for two or more years is inversely related to age, with 54% of 15–19 year olds and 1% of 35–39 year olds reporting a desire to postpone the next birth by two years or longer.

In Table 4.10B the percentage of married men who want no more children (58%) is similar to that of women, with a corresponding increase with parity and

age. However, compared to women, smaller percentages of men report wanting to postpone the next birth for two or more years (6% vs. 12% for women) and a larger percentage is undecided (13% of men compared to 7% of women). The differences between men and women appear to be most pronounced at parity one. Nineteen percent of men with one living child compared to 45% of women in that category want to postpone the next birth for two or more years. Furthermore, at parity one, 19% of men are undecided about having any more children and another 11% say they want more but do not know when. This contrasts to lower percentages for women at parity one, where the corresponding percentages are 9% and 5%, respectively.

In order to better understand the relationship between number of living children and desire for no more births, Table 4.11 shows this association controlling for fecundity and selected demographic characteristics. While in the aggregate, there appears to be no affect of residence on desire for more children, the trend by parity indicates that urban low-parity women are more likely to want no more births than rural low-parity women. Urban women with 0, 1, and 2 living children report wanting no more children at levels of 5%, 16% and 80%, respectively, compared to rural women at 0%, 5% and 67%, respectively. When the correlation between parity and age is controlled, both variables appear to have strong independent effects on desire for no more children. This is most noticeable at parities one and two. Only 3% of women 15–24 years of age with one living child state they want no more children, whereas 64% of women 35–44 years of age want no more children. Similarly, 47% of 15–24 year old women with two living children want no more births, and 90% of 35–44 year olds at the same parity want no more births. Education, while in the aggregate appears to have no effect, at parities one and two there is a direct relationship between wanting no more children and level of education.

Table 4.1
Three-Year Period Age-Specific Fertility Rates for Several Time Periods Among All Women Aged 15–44
Reproductive Health Survey: Albania 2002

	Albania	Albania	Albania
Age Group	**1993–1996 ***	**1996–1999 ****	**1999–2002 *****
15–19	41	38	35
20–24	207	182	170
25–29	221	185	167
30–34	120	92	105
35–39	76	43	34
40–44	0	10	8
Total Fertility Rate	3.3	2.8	2.6

*Period from August 1993 – July 1996

**Period from August 1996 – July 1999

***Period from August 1999 – July 2002

Table 4.2
Three-Year Period* Age–Specific and Total Fertility Rates, Among Women Aged 15–44
Reproductive and Demographic Health Surveys (RHS and DHS)
in Selected Eastern European and Former Soviet Union Countries
Albania Reproductive Health Survey 2002, Final Report

Region and Country	Time Period	Age–Specific Fertility Rates (per 1,000 women) †						TFR ‡	GFR §
		15–19	20–24	25–29	30–34	35–39	40–44	15–44	15–44
Eastern Europe									
Albania, 2002	1999–2001	35	170	167	105	34	8	2.6	89
Czech Rep., 1993	1990–1992	49	176	92	41	11	4	1.9	62
Moldova, 1997	1994–1996	57	158	88	40	17	6	1.8	64
Romania, 1999	1997–1999	36	100	83	29	13	2	1.3	49
Russia (three oblasts), 1999 ¶	1996–1998	39	101	73	28	11	7	1.3	44
Ukraine, 1999	1997–1999	49	115	66	36	14	4	1.4	49
Caucasus									
Armenia, 2000	1998–2000	50	149	88	35	16	3	1.7	56
Azerbaijan, 2001	1998–2000	44	151	133	58	19	9	2.1	71
Georgia, 1999	1997–1999	64	113	92	48	21	7	1.7	61
Central Asia									
Kazakhstan, 1999	1997–1999	40	167	106	64	24	9	2.1	67
Kyrgyz Rep., 1997	1995–1997	75	246	179	113	47	13	3.4	118
Turkmenistan, 2000	1998–2000	30	184	195	105	48	14	2.9	103
Uzbekistan, 1996	1994–1996	61	266	176	114	39	9	3.3	123

* Three years prior to the interview.

† Age at pregnancy outcome.

‡ TFR: Total Fertility Rate (number of births per woman).

§ GFR: General Fertility Rate (births divided by the number of women age 15–44), expressed per 1,000 women

¶ Yekaterinburg, Perm, and Ivanovo, respectively (predominantly urban sample).

Table 4.3 A
Age-Specific Fertility Rates and Total Fertility Rates by Selected Characteristics Among All Women Aged 15–44
Reproductive Health Survey: Albania 2002

Characteristics	Age-Specific Fertility Rate (per 1000) (ASFR)						Total Fertility Rate *	GFR †
	15–19	20–24	25–29	30–34	35–39	40–44		
Total	35	170	167	105	34	8	2.6	89
Strata								
Metro Tirana	37	143	170	98	30	(5)	2.4	85
Other Urban	38	184	159	100	45	(4)	2.7	92
Other Rural	33	172	171	111	27	(11)	2.6	89
Residence								
Urban	37	167	164	100	41	(4)	2.6	89
Rural	33	172	169	109	27	(11)	2.6	90
Education Level								
Primary or Less	51	187	171	105	28	(6)	2.7	96
Secondary	14	180	169	99	34	11	2.5	83
Post-Secondary	(6)	54	136	134	67	(4)	2.0	75
Socioeconomic Index								
Low	37	196	194	103	34	(9)	2.9	98
Medium	31	153	142	105	30	(8)	2.3	80
High	50	147	181	116	51	(0)	2.7	100

Note: All rates in this table are calculated based on births in the last three years (August 1999–July 2002) and ages of mothers at time of birth.

* The total fertility rate (TFR) is calculated as the sum of ASFR's for each year of age from age 15 to 44.

† The general fertility rate (GFR) is calculated as the number of births per 1000 women 15–44.

( ) Rates considered unstable due to numerators of less than 15 cases.

Table 4.3 B
Age-Specific Fertility Rates and Total Fertility Rates by Selected Characteristics
Among All Men Aged 15–49
Reproductive Health Survey: Albania 2002

	Age-Specific Fertility Rate (per 1000) (ASFR)							Total Fertility	
Characteristics	15–19	20–24	25–29	30–34	35–39	40–44	45–49	Rate *	GFR †
Total	(1)	31	134	137	58	30	(8)	2.0	59
Strata									
Metro Tirana	(3)	36	125	125	46	(19)	(15)	1.8	52
Other Urban	(0)	(14)	109	163	52	38	(12)	2.0	62
Other Rural	(0)	38	152	122	68	29	(0)	2.1	60
Residence									
Urban	(0)	25	111	150	51	32	(15)	1.9	58
Rural	(1)	36	154	123	66	28	(0)	2.0	60
Education Level									
Primary or Less	(1)	61	142	143	70	28	(10)	2.3	65
Secondary	(1)	(59)	144	127	49	30	(9)	1.8	61
Post-Secondary	(0)	(4)	65	144	(53)	(43)	(0)	1.5	50
Socioeconomic Index									
Low	(0)	41	134	156	63	31	(3)	2.1	59
Medium	(1)	20	141	114	54	(10)	(8)	1.7	55
High	(0)	(45)	108	155	(54)	93	(40)	2.5	77

Note: All rates in this table area calculated based on births in the last three years (August 1999–July 2002) and ages of fathers at time of birth.

* The total fertility rate (TFR) is calculated as the sum of ASFR's for each year of age from ages 15 to 49.

† The general fertility rate (GFR) is calculated as the number of births per 1000 men 15-49.

( ) Rates caonsidered unstable due to numerators of less than 15 cases.

Table 4.4 A
Percent Distribution of Number of Live Births by Current Age of Respondents Among all Women and Among Married Women Aged 15–44
Reproductive Health Survey: Albania 2002

	All Women						
		Age Group (Current Age)					
Number of Live Births	Total	15–19	20–24	25–29	30–34	35–39	40–44
0	37.8	95.8	64.0	23.0	9.6	6.6	4.1
1	12.8	3.8	25.0	28.3	10.9	5.8	4.6
2	27.1	0.4	9.7	39.0	47.5	41.7	35.5
3	14.9	0.0	1.3	9.5	25.4	31.6	28.2
4 +	7.4	0.0	0.0	0.2	6.7	14.3	27.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
No. of Cases	5,697	1,094	936	946	1,067	958	696

	Married Women						
		Age Group (Current Age)					
Number of Live Births	Total	15–19	20–24	25–29	30–34	35–39	40–44
0	7.5	55.6	27.5	5.7	1.1	2.9	1.2
1	18.6	40.0	50.3	34.0	11.8	5.1	3.7
2	40.4	4.5	19.5	48.4	51.4	43.6	36.4
3	22.4	0.0	2.6	11.7	28.3	33.4	29.9
4 +	11.1	0.0	0.0	0.2	7.4	15.0	28.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
No. of Cases	3,965	97	502	800	1,004	906	656

Table 4.4 B
Percent Distribution of Number of Live Births by Current Age of Respondents Among All Men and Among Married Men Aged 15–49
Reproductive Health Survey: Albania 2002

	All Men							
		Age Group (Current Age)						
Number of Live Births	Total	15–19	20–24	25–29	30–34	35–39	40–44	45–49
0	45.5	100.0	94.9	63.4	21.4	7.0	1.6	2.7
1	11.5	0.0	2.6	22.9	33.5	15.4	6.8	3.2
2	24.9	0.0	1.5	12.0	36.8	51.3	45.8	38.0
3	11.8	0.0	1.0	1.6	6.8	20.0	32.3	27.6
4 +	6.3	0.0	0.0	0.2	1.6	6.3	13.5	28.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
No. of Cases	1,740	401	189	218	253	255	277	147

	Married Men							
		Age Group (Current Age)						
Number of Live Births	Total	15–19	20–24	25–29	30–34	35–39	40–44	45–49
0	10.3	**	61.7	39.1	10.4	2.7	1.0	1.4
1	18.9	**	19.2	38.0	38.3	16.2	6.2	3.3
2	40.8	**	11.5	20.0	41.7	53.4	46.4	37.6
3	19.6	**	7.6	2.6	7.8	21.1	32.7	28.3
4 +	10.4	**	0.0	0.3	1.8	6.6	13.7	29.3
Total	**100.0**	**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
No. of Cases	1,023	0	32	123	215	242	270	141

**Percentages are not shown when base is less than 25 cases.

Table 4.5 A
Percent of Women Aged 15–44 Who Had Their First Sexual Relation, First Marriage, and First Birth Before Selected Ages, and Median Age at These Events, by Current Age
Reproductive Health Survey: Albania 2002

	Age at First Sexual Intercourse					Has Had	Never Had	Median	No. of
Current Age	<15	<18	<20	<22	<25	Intercourse	Intercourse	Age †	Cases
15–19	1.2	(10.8)	(13.8)	NA	NA	13.8	86.2	**	1,094
20–24	1.6	16.3	35.1	(50.2)	(55.2)	55.2	44.8	21.5	935
25–29	0.3	12.4	36.9	61.0	80.7	85.1	14.9	20.7	945
30–34	0.3	8.7	30.8	59.4	82.3	92.4	7.6	21.0	1,066
35–39	0.4	10.8	32.2	55.2	82.9	97.2	2.8	21.3	957
40–44	0.6	9.6	31.4	56.6	83.4	97.2	2.8	21.1	696
Total	**0.8**	**11.5**	**29.2**	**47.4**	**63.3**	**69.9**	**30.1**	**21.1**	**5693***

	Age at First Marriage					Ever in	Never in	Median	No. of
Current Age	<15	<18	<20	<22	<25	Union	Union	Age †	Cases
15–19	0.6	(6.8)	(9.5)	NA	NA	9.5	90.5	**	1,094
20–24	0.9	11.2	27.8	(43.6)	(49.8)	49.8	50.2	22.2	936
25–29	0.1	7.9	28.0	51.8	75.6	81.7	18.3	21.8	946
30–34	0.6	6.7	23.5	51.4	79.1	91.4	8.6	21.9	1,067
35–39	0.4	7.7	24.6	47.6	76.9	96.2	3.8	22.2	958
40–44	0.2	6.8	25.4	51.5	79.0	97.2	2.8	21.9	696
Total	**0.5**	**7.8**	**22.4**	**40.7**	**58.5**	**67.2**	**32.8**	**21.9**	**5,697**

	Age at First Live Birth					Has Had	Never Had	Median	No. of
Current Age	<15	<18	<20	<22	<25	Live Birth	Live Birth	Age†	Cases
15–19	0.2	(2.5)	(4.2)	NA	NA	4.2	95.8	**	1,094
20–24	0.2	3.8	15.1	(28.3)	(36.0)	36.0	64.0	23.6	936
25–29	0.0	1.6	13.7	37.0	65.8	77.0	23.0	23.3	946
30–34	0.5	2.7	9.7	31.9	69.2	90.4	9.6	23.3	1,066
35–39	0.2	2.1	11.7	31.0	65.3	93.4	6.6	23.7	955
40–44	0.0	2.6	9.8	33.2	66.5	95.9	4.1	23.5	696
Total	**0.2**	**2.6**	**10.4**	**26.3**	**48.3**	**62.2**	**37.8**	**23.4**	**5693***

* Excludes 4 cases not reporting the date at first sexual intercourse and 4 cases not reporting date at first birth

** Omitted because less than 50% in that age group reported the variable of interest by the end of the interval

( ) Time exposed partially truncated because not all cases have exposure throughout the period of analysis

NA. Not applicable

† Life table method used in calculation of median age at first intercourse, first marriage and first birth to control for truncated cases

Table 4.5 B
Percent of Men Aged 15–49 Who Had Their First Sexual Relation and First Marriage Before Selected Ages and Median Age at These Events, by Current Age
Reproductive Health Survey: Albania 2002

	Age at First Sexual Intercourse								
Current Age	<15	<18	<20	<22	<25	Has Had Intercourse	Never Had Intercourse	Median Age	No. of Cases
15–19	0.6	(4.5)	(4.8)	N/A	N/A	4.8	95.2	**	401
20–24	1.5	21.5	40.9	(56.1)	(61.3)	61.3	38.7	21.5	188
25–29	2.1	15.3	38.6	56.1	80.4	93.6	6.4	20.9	209
30–34	0.4	8.3	39.2	53.8	76.1	99.4	0.6	20.9	241
35–39	0.2	8.3	26.7	48.1	72.2	99.8	0.2	21.9	235
40–44	0.0	8.3	30.8	53.8	74.5	100.0	0.0	21.3	247
45–49	0.0	5.4	22.1	51.3	75.4	100.0	0.0	21.7	132
Total	**0.7**	**10.2**	**27.9**	**43.7**	**59.5**	**74.3**	**25.7**	**21.5**	**1,653***

	Age at First Marriage								
Current Age	<15	<18	<20	<22	<25	Ever in Union	Never in Union	Median Age	No. of Cases
15–19	0.0	(0.0)	(0.0)	N/A	N/A	0.0	100.0	**	401
20–24	0.0	1.0	4.3	(7.7)	(13.7)	13.7	86.3	**	189
25–29	0.0	0.0	3.1	11.1	28.7	61.2	38.8	26.4	218
30–34	0.0	0.0	2.1	6.0	31.6	87.7	12.3	26.9	253
35–39	0.0	0.7	1.0	6.4	30.8	95.5	4.5	26.7	255
40–44	0.0	1.1	5.1	11.0	33.6	99.4	0.6	26.6	277
45–49	0.0	0.5	1.5	13.8	35.8	99.0	1.0	25.8	147
Total	**0.0**	**0.5**	**2.4**	**7.4**	**23.3**	**61.0**	**39.0**	**26.5**	**1,740**

* Excludes 87 cases not reporting the date at first sexual intercourse.

** Omitted because less than 50% in that age group reported the variable of interest by the end of the interval.

( ) Time exposed partially truncated because not all cases have exposure throughout the period analisys

NA. Not applicable

† Life table method used in calculation of median age at first intercourse, first marriage and first birth to control for truncated cases.

Table 4.6
Median Age at First Sexual Intercourse, First Marriage and First Birth Among Women Aged 15–44 and Men Aged 15–49 by Selected Characteristics Reproductive Health Survey: Albania 2002

	Women			Men	
Characteristics	Median Age at First Intercourse	Median Age at First Marriage	Median Age at First Birth	Median Age at First Intercourse	Median Age at First Marriage
Total	21.1	21.9	23.4	21.5	26.5
Strata					
Metro Tirana	21.1	22.5	24.1	20.3	27.0
Other Urban	21.4	22.7	24.0	20.8	27.4
Other Rural	21.0	21.5	22.9	22.3	25.9
Residence					
Urban	21.3	22.7	24.1	20.6	27.4
Rural	21.0	21.5	22.9	22.2	25.8
Education Level					
Primary or Less	20.5	21.0	22.5	22.0	26.0
Secondary Incomplete	20.7	22.1	23.5	21.5	25.2
Secondary Complete	21.7	22.7	24.0	21.2	26.7
Post-Secondary	23.3	25.1	26.6	20.3	28.6

Table 4.7
Sexual Activity Status by Current Marital Status for Women Aged 15–44 and Men Aged 15–49 (Percent Distribution)
Reproductive Health Survey: Albania 2002

		Women Marital Status		
Sexual Activity Status	**Total**	**Married**	**Previously Married**	**Never Married**
Never Had Intercourse	30.1	0.0	0.0	91.8
Ever Had Intercourse	69.9	100.0	100.0	8.2
Within The Last Month	50.3	75.3	2.7	3.9
1–3 Months Ago	8.9	12.5	2.7	1.9
Over 3 Months But Within Last Year	2.6	3.2	9.9	0.8
One Year or Longer	3.7	2.5	76.4	1.4
Currently Pregnant	3.6	5.4	2.5	0.0
Postpartum	0.7	1.1	0.0	0.0
Unknown Interval	0.2	0.1	5.8	0.1
Total	100.0	100.0	100.0	100.0
No. of Cases	5,697	3,965	88	1,644

		Men Marital Status		
Sexual Activity Status	**Total**	**Married**	**Previously Married**	**Never Married**
Never Had Intercourse	24.4	0.0	**	62.5
Ever Had Intercourse	75.6	100.0	**	37.5
Within The Last Month	55.6	82.5	**	14.4
1–3 Months Ago	8.1	6.2	**	11.0
Over 3 Months But Within Last Year	2.7	0.8	**	5.5
One Year or Longer	2.9	1.4	**	4.9
Partner Currently Pregnant	2.4	3.9	**	0.0
Partner Postpartum	0.9	1.5	**	0.0
Unknown Interval	3.0	3.7	**	1.8
Total	100.0	100.0	**	100.0
No. of Cases	1,740	1,023	14	703

** Percentages are not shown when base is less than 25 cases.

Table 4.8
Abortions * per 1000 Births Reported in Reproductive Health Survey and By Albanian Institute of Statistics (INSTAT)†
Three Year Period: 1999–2001

	INSTAT	RHS (CI)‡	Under-Reporting in RHS (CI)‡
Abortion/1000 Births	200	73 (46 to 100)	64% (-77% to -50%)

* Arborteve me Nderprerje (Induced Abortions)
† Instituti I Statistikes (2003): Http:/www.Instat.gov.Al/graphics/doc/tablelat/shno1.html
‡ 95% confidence interval

Table 4.9 A
Planning Status of the Last Pregnancy Among Women 15–44 Years of Age With at Least One Pregnancy Since January 1997, by Selected Characteristics (Percent Distribution)
Reproductive Health Survey: Albania 2002

Characteristics	Planning Status of Last Pregnancy				Total	No. of Cases
	Intended	Mistimed	Unwanted	Not Sure		
Total	86.7	5.8	7.0	0.5	100.0	2,275
Last Pregnancy Outcome						
Current Pregnancy	86.7	9.3	3.0	1.0	100.0	222
Live Birth	91.7	4.8	3.2	0.3	100.0	1,811
Induced Abortion	22.2	11.6	64.7	1.5	100.0	149
Other Pregnancy Outcomes *	78.8	8.9	11.4	0.8	100.0	93
Strata						
Metro Tirana	83.3	7.9	8.5	0.3	100.0	844
Other Urban	85.3	7.1	7.3	0.3	100.0	730
Other Rural	88.5	4.5	6.4	0.6	100.0	701
Residence						
Urban	84.5	7.6	7.6	0.3	100.0	1,410
Rural	88.4	4.5	6.5	0.6	100.0	865
Age at The Time of The Last Pregnancy Outcome†						
< 20	88.5	10.4	1.1	0.0	100.0	135
20–24	92.0	6.6	1.4	0.1	100.0	653
25–29	87.1	6.7	5.6	0.5	100.0	798
30–34	82.0	3.5	13.2	1.3	100.0	498
35+	78.2	1.7	20.1	0.0	100.0	191
Marital Status at Last Pregnancy						
Currently Married	86.7	5.7	7.1	0.5	100.0	2,171
Not Currently Married	86.7	8.2	5.2	0.0	100.0	104
Living Children						
0	87.4	11.3	1.3	0.0	100.0	105
1	93.7	5.0	1.0	0.2	100.0	679
2	87.6	6.7	5.6	0.0	100.0	934
3	80.1	5.9	12.1	2.0	100.0	419
4 +	71.2	0.9	27.9	0.0	100.0	138
Education Level						
Primary or Less	87.5	5.4	6.7	0.4	100.0	1,072
Secondary Incomplete	84.4	8.5	7.1	0.0	100.0	158
Secondary Complete	86.5	5.0	7.8	0.8	100.0	795
Post-Secondary	84.1	10.0	5.9	0.0	100.0	250

* Includes pregnancies resulting in stillbirth, miscarriage or ectopic pregnancy.

† Age of the woman at the time of pregnancy outcome.

Table 4.9 B
Planning Status of the Last Live Birth Among Men 15–49 Years of Age With Partner Having at Least One Live Birth Since January 1997, by Selected Characteristics (Percent Distribution)
Reproductive Health Survey: Albania 2002

Characteristics	Planning Status of Last Pregnancy				Total	No. of Cases
	Intended	Mistimed	Unwanted	Not Sure		
Total	98.4	1.0	0.1	0.5	100.0	488
Strata						
Metro Tirana	96.4	3.1	0.5	0.0	100.0	181
Other Urban	98.8	0.6	0.0	0.6	100.0	162
Other Rural	98.7	0.7	0.0	0.6	100.0	145
Residence						
Urban	98.3	1.2	0.2	0.4	100.0	312
Rural	98.5	0.9	0.0	0.6	100.0	176
Age at Time of The Last Live Birth*						
< 25	98.6	1.4	0.0	0.0	100.0	27
25–29	97.9	2.1	0.0	0.0	100.0	152
30–34	99.3	0.7	0.0	0.0	100.0	189
35+	97.4	0.0	0.4	2.2	100.0	120
Living Children						
0–1	98.9	1.1	0.0	0.0	100.0	164
2	98.0	1.6	0.0	0.4	100.0	227
3 +	98.2	0.0	0.4	1.4	100.0	97
Education Level						
Primary or Less	99.0	0.3	0.0	0.6	100.0	212
Secondary Incomplete	**	**	**	**	**	6
Secondary Complete	97.6	1.8	0.2	0.5	100.0	214
Post-Secondary	97.8	2.2	0.0	0.0	100.0	56

* Age of the man at the time of live birth outcome

**Percentages are not shown when base is less than 25 cases.

Table 4.10 A
Fertility Preferences of Currently Married Women Aged 15–44 Years
By Number of Living Children and by Age Group
(Percent Distribution)
Reproductive Health Survey: Albania 2002

		Number of Living Children†				
Preference for Children	**Total**	**0**	**1**	**2**	**3**	**4 +**
Want a Child Now	3.4	29.2	6.5	1.4	0.3	0.3
Want a Child Within a Year	3.1	21.0	6.1	1.4	1.0	0.3
Want a Child in 1–2 Years	5.8	14.1	17.7	3.6	1.0	0.3
Want a Child After 2 or More Years	12.4	8.7	44.6	7.6	1.9	0.1
Want More But Do Not Know When	2.7	3.5	4.8	2.9	1.3	0.9
Want No (no more) Children	62.5	2.0	10.0	72.5	86.7	91.5
Undecided	7.3	6.6	8.5	8.6	5.8	3.6
Subfecund, Infecund	2.8	14.9	1.8	2.1	1.9	2.9
Total	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	3,961*	211	783	1,864	809	294

		Age Group					
Preference for Children	**Total**	**15–19**	**20–24**	**25–29**	**30–34**	**35–39**	**40–44**
Want a Child Now	3.4	11.3	7.8	4.5	2.8	1.7	1.2
Want a Child Within a Year	3.1	5.1	9.6	3.7	2.9	1.1	0.5
Want a Child in 1–2 Years	5.8	6.4	15.0	12.1	5.1	1.1	0.3
Want a Child After 2 or More Years	12.4	53.6	38.4	23.2	5.5	1.1	0.0
Want More But Do Not Know When	2.7	5.7	3.9	3.7	3.1	2.2	0.8
Want No (no more) Children	62.5	5.1	15.2	41.1	68.4	84.2	89.9
Undecided	7.3	12.9	9.5	10.6	11.1	4.8	0.9
Subfecund, Infecund	2.8	0.0	0.6	1.1	1.1	3.8	6.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	3,961*	96	501	800	1,003	906	655

* Excludes 4 women with missing information.

† Women who were pregnant at the time of interview are classified as having one more child than their actual number of living children.

Table 4.10 B
Fertility Preferences of Currently Married Men Aged 15–49 Years
By Number of Living Children and by Age Group
(Percent Distribution)
Reproductive Health Survey: Albania 2002

		Number of Living Children †				
Preference for Children	**Total**	**0**	**1**	**2**	**3**	**4 +**
Want a Child Now	4.1	26.2	8.2	0.7	0.0	0.0
Want a Child Within a Year	4.3	25.6	8.6	0.5	0.8	0.4
Want a Child in 1–2 Years	6.2	9.1	21.5	2.9	0.0	0.0
Want a Child After 2 or More Years	5.6	3.2	18.6	4.1	0.0	0.0
Want More But Do Not Know When	3.7	6.9	10.9	2.0	1.0	0.0
Want No (no more) Children	58.2	4.5	9.9	74.7	85.5	76.2
Undecided	12.9	3.8	18.8	13.4	9.4	14.1
Subfecund, Infecund	4.9	20.7	3.5	1.7	3.4	9.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
No. of Cases	1,022*	88	221	473	170	70

		Age Group					
Preference for Children	**Total**	**20–24**	**25–29**	**30–34**	**35–39**	**40–44**	**45–49**
Want a Child Now	4.1	15.6	14.6	5.7	2.1	0.3	0.3
Want a Child Within a Year	4.3	19.1	12.0	6.9	1.4	1.6	0.3
Want a Child in 1–2 Years	6.2	8.9	15.2	13.9	3.4	1.7	0.3
Want a Child After 2 or More Years	5.6	17.8	14.6	12.7	2.7	0.2	0.0
Want More But Do Not Know When	3.7	5.1	8.9	6.6	4.0	0.5	0.6
Want No (no more) Children	58.2	14.0	15.3	32.0	64.7	84.0	84.2
Undecided	12.9	19.5	11.6	19.4	18.2	7.8	6.0
Subfecund, Infecund	4.9	0.0	7.8	2.9	3.5	4.0	8.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	1,022*	32	122	215	242	270	141

* Excludes 1 man with missing information.

† Men whose partner was pregnant at the time of interview are clasified as having one more child than their actual number of living children.

Table 4.11
Percentage of Fecund Married Women Reporting They Want no More Children by Number of Living Children and Selected Characteristics
Fecund Women 15–44 Years of Age
Reproductive Health Survey: Albania 2002

		Number of Living Children†				
Characteristics	**Total**	**0**	**1**	**2**	**3**	**4 +**
Total	64.3	2.3	10.1	74.0	88.5	94.2
No. of Cases	3,866*	183	769	1,833	795	286
Strata						
Metro Tirana	62.6	0.0	17.5	78.8	90.3	94.1
Other Urban	66.9	7.2	13.8	79.7	87.2	93.3
Other Rural	63.3	0.0	5.3	66.9	88.6	94.5
Residence						
Urban	65.8	4.8	16.1	79.8	87.9	93.8
Rural	63.1	0.0	5.2	67.2	88.8	94.4
Age Group						
15–24	13.3	2.5	2.7	46.8	69.4	**
25–34	56.3	0.0	7.7	65.4	78.1	81.2
35–44	91.7	**	63.7	90.3	95.6	96.8
Education Level						
Primary or Less	61.1	0.8	4.9	66.3	87.5	94.0
Secondary Incomplete	58.4	**	16.0	66.0	90.5	‡
Secondary Complete	71.0	8.5	15.3	81.7	90.3	94.3
Post-Secondary	63.1	0.0	20.9	85.6	85.1	‡

* Excludes 4 women with missing information.

† Women who were pregnant at the time of interview are clasified as having one more child than their actual number of living children.

‡ Percentages are not shown when base is less than 25 cases.

Chapter 5 Maternal and Child health

Adequate perinatal care is an essential approach in identifying and addressing risk factors that may affect the health of mothers and their babies. In Albania, perinatal care has been organized as a vertical program controlled by the Ministry of Health and for many years women have had free access. Currently, under the new health reform, it is included in all three sub systems: primary health care, secondary health care and tertiary health care.

Perinatal care consists of three components: preconception care, prenatal care and postnatal care. Preconceptional counseling and prenatal care are generally offered by primary care providers and consists of a wide range of information. Information includes risks associated with pregnancies, health risk factors that can affect the development of the fetus (e.g. tobacco and alcohol), maternal infection (e.g. rubella, toxoplasma, HIV and other sexually transmitted diseases), risks associated with maternal health conditions, and risks associated with genetic conditions.

Efforts are being made by the Ministry of Health of Albania to organize preconception counseling, especially in addressing the high prevalence of genetic conditions in some areas of the country. Nevertheless, preconception counseling is not routinely provided during health care visits in spite of the essential role the primary care provider plays in modifying women's health behaviors (many healthy behaviors must be in place before the pregnancy is recognized) and in identifying medical conditions that require special attention during pregnancy.

The use of timely and periodic prenatal care can assist in the identification and/or prevention of perinatal morbidity and prevention of mortality. In Albania, public prenatal care is organized within the primary health care subsystem, and in urban areas, it is offered in women's clinics (policlinics), and in both urban and rural areas the service is provided by family doctors (GP's) in their health centers. There are 95 women's clinics and 582 health centers in the urban areas. Prenatal care includes a general risk assessment, consisting of a medical examination and a series of laboratory tests, such as blood, urine, vaginal bacteriological exams, screening for sexually transmitted infections, and isoimmunization Rh. Pregnant women in Albania are entitled to use these public services free of charge. In urban areas, mainly in Tirana, there are an increasing number of private clinics that offer prenatal services, especially the use of ultrasound exams during pregnancy. Although women's clinics are now separated from well baby clinics in urban areas, postpartum care is performed jointly with infant care visits during the first year postpartum.

The Albanian Reproductive Health Survey looked at a number of factors which can have a considerable impact on the health of a woman, the health of her baby, and the outcome of her pregnancy. The instrument used for the survey covered issues such as: the use of health care services related to pregnancy; health related behaviors during pregnancy; the place of delivery; type and assistance at delivery; and postpartum behaviors, including infant feeding practices. However, the sample size allows the ability to estimate infant and child mortality indicators for only the ten year period prior to the survey.

In this chapter selected aspects of maternal and child care in Albania will be examined. Such aspects include sources of health care,

utilization of maternal health care clinics, quality of care, etc. The aim is to identify subgroups with specific needs of care and to investigate maternal and child outcomes, which may be related to the availability and quality of maternity care services. All this information will be used to help direct or modify program interventions.

Prenatal care

Prenatal care is most effective when it is initiated in the early stages of pregnancy, is continued throughout gestation, and is comprehensive. For the optimal health of the mother and child, it is recommended that every pregnant woman starts seeing a health care provider for prenatal care examinations during her first trimester of pregnancy.

This section describes the use of prenatal care for all pregnancies ending in a live birth since January 1997. Women participating in the survey were asked about the total number of prenatal care visits they have had during their pregnancy (information did not include visits made just to confirm pregnancy or the use of health care services for the delivery only). Another question regarded the week or month of gestation when they had their first visit for prenatal care.

Table 5.1 displays prenatal care which is distributed by pregnancy trimester of first visit and number of prenatal visits by selected categories. Nineteen percent of all pregnancies ending in a live birth since January 1997 have not received any prenatal care by health professionals. The figure is the highest when compared with Eastern European countries and it is among the highest even when compared with the Caucasus Region and Central Asian countries (CDC and ORC MACRO, 2004).

Although there is a considerable amount of variation between countries on how many prenatal visits a pregnant woman should make and when they should make their first visit, it is generally accepted that the first visit should take place within the first three months after conception. Among pregnant women who had a live birth since January 1997, including those who have not had any prenatal visits, only 59% received their first prenatal care during the first trimester. During the second trimester the first visit was made by 18 % of pregnant women, and the remaining 3% had their first prenatal visit only during the third trimester. Almost one-fifth of women (19%) reported no prenatal care.

While there are virtually no differences between women living in Tirana and women living in other urban areas in Albania, rural women are by far, more likely (two and a half times more) to carry their birth to term without having any prenatal visits. In addition to rural women there are two additional socio-economic factors, which increases the risk of not having any prenatal visits: level of education and socio economic index. One out of four women among those with only a primary education or less have not had any visits, compared to 7% for women who have had their university studies. The picture is similar when considering the socioeconomic index; women with a low socioeconomic index are almost two and a half times more likely to not have had any prenatal care visits.

Other characteristics that influence not having any prenatal care visits are the age of the mothers and the birth order. Table 5.1 shows a steady trend; women of older ages are more inclined to not receive any prenatal care and among those in the 35–44 age group the likelihood of not receiving prenatal care is almost twice as high as those under 20 years old. Almost 30% of women who have had three or more births made no prenatal visits.

The place of residence, education, and socioeconomic index are also three important factors which influence the early starting of prenatal care. More women living in an urban area started their prenatal care earlier compared to women living in a rural area: 71% versus 51%. Differences among various educational and socio-economic groups are even higher. Only one-fourth of women with a post-secondary education had their first visit after the first trimester or no visits, while almost half of the women with a primary education do so. When analyzing the socioeconomic index, the picture is the same: 79% of women classified in the high socioeconomic index start their prenatal care during the first trimester versus only 49 % of those classified in the low index.

Prenatal care should not only start early but also continue throughout pregnancy, according to the recommended standards of periodicity. To asses the adequacy of prenatal care it is necessary to monitor both the time of the first visit and the number of prenatal care visits. In our study the relative majority of women (slightly less than half of those who had some prenatal care) have had only 1–3 visits. The average number of prenatal visits among all pregnant women was around 3 ranging from no visits at all to 27 visits.

Women living in urban areas, women with higher education, and those with a higher socioeconomic status use the prenatal care services more frequently compared to the women living in rural areas, with less education and a lower socioeconomic status.

When compared to other countries in the sub-region, the same differences between areas of residence and education of mothers are noticed, but the range of differences is more similar to the Caucasus countries than Eastern Europe. Generally, in all of these countries, urban living and better educated women use the health services more frequently for prenatal care, compared to women living in rural areas and having a lower educational status. Nevertheless, only among countries such as Georgia, Azerbaijan or Armenia are differences as high as those seen in Albania (CDC and ORC MACRO, 2004).

The baby's weight at birth does not seem to be associated with onset of prenatal care. The proportions of the two categories – under 2500 kg and 2500 kg and above– are quite similar.

Prenatal care is inadequate in some of the countries of Eastern Europe and the former Soviet Union (successor states of USSR). In recent reproductive health surveys (RHS) and demographic and health surveys (DHS) conducted in the region, the proportion of pregnant women with no prenatal care was less than 1% in Czech Republic, 1% in Moldova, 4% in Russia, 8% in Armenia, 9% in Ukraine and Georgia, between 2% and 55% in Central Asian Republics, 11% in Romania, and 30% in Azerbaijan (CDC and ORC MACRO, 2004). Late prenatal care is also common. With the exception of Czech Republic, where more than 90% of women began receiving care in the first trimester, in all other countries less than three-fourths of women entered prenatal care early. Late prenatal care was more prevalent in the Caucasus region than in other regions. In the United States, in 2000, 83% of pregnant women began prenatal care in the first trimester, while only 4% had no prenatal care or late care (third trimester) (CDC, 2002).

In Albania there are no official indicators to measure the adequacy of prenatal care. In the United States the adequacy of prenatal care is assessed by using the Adequacy of Prenatal Care Utilization Index (APNCU), also known as the Kotelchuck index (Kotelchuck, 1994). This index is based

on the recommendation of the American College of Obstetricians and Gynecologists, and it is used in all similar reproductive surveys, which makes it a good comparison indicator. It combines the month when prenatal care begins with the number of visits received. Inadequate care is defined as no or late prenatal care or less than 50% of recommended visits. The three remaining levels (intermediate, adequate and adequate plus) require an early initiation of care by the fourth month of gestation. Intermediate care requires 50%–79% of the recommended number of visits; adequate care requires 80–109%; and adequate plus level requires 110% or more of the recommended number of visits.

Using the recommendations of the American College of Obstetricians and Gynecologists for number of visits, as has been used in other reproductive health surveys in Eastern Europe, the adequacy of prenatal care in Albania assessed by the Kotelchuck Index compared with four other countries is shown below. The percentage of women in each category is shown across multiple countries (figure 5.1) and for Albania (figure 5.2)

Figure 5.1
Adequacy of Prenatal Care Utilization Index*, Selected Countries in Eastern Europe

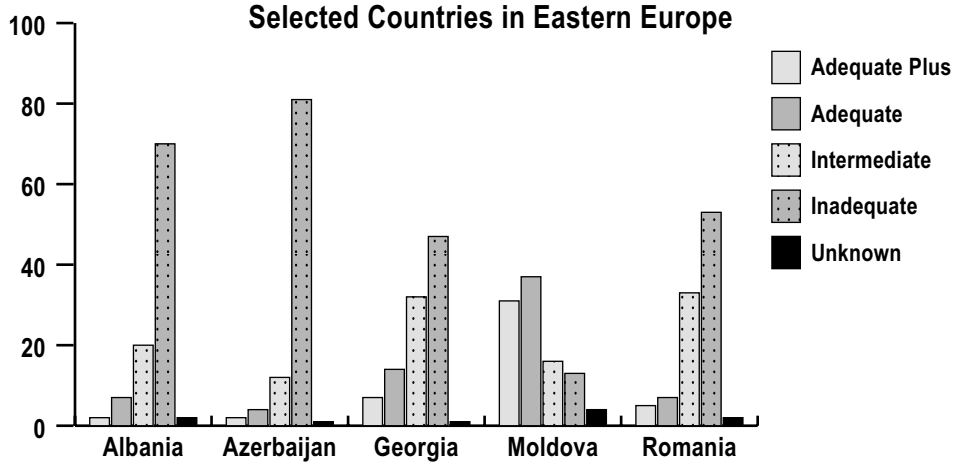
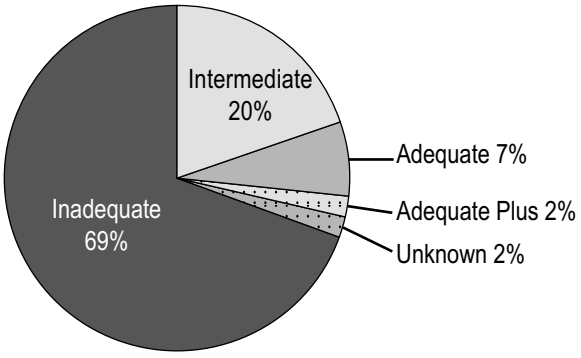


Figure 5.2
Adequacy of Prenatal Care Utilization Index*
Births in the 5 Years Prior to the Survey



*Also known as the Kotelchuck Index, it is a measure of adequacy of prenatal care based on initiation of such care (no prenatal care automatically warrants "Inadequate" level) and the number of required visits adjusted for the length of gestation and the gestational age at first visit.

Inadequate care ranges from 13% in Moldova to 81% in Azerbaijan. For Albania, inadequate care is estimated at 70% of the women eligible for prenatal care with live births since 1997. Adequate and Adequate Plus care ranges from 6% in Azerbaijan to 68% in Moldova. The percentage of women with adequate or adequate plus care in Albania is estimated at 9%, somewhat higher than Azerbaijan and somewhat lower than Romania.

In the prenatal health care package an important component is the dissemination of health information. Especially when preconception care is missing, the first prenatal visit is a critical opportunity to screen women for behavioral risk factors such as tobacco or alcohol use, medical and genetical risks, occupational risks and to provide comprehensive counseling. Counseling should include information about maternal behaviors and exposures that may affect the health of the fetus, nutrition, rest, and early signs and symptoms of pregnancy complications. In addition, approaching the time of delivery, counseling should prepare women for what they will face when giving birth, distribute accurate information regarding labor and delivery, and advise about techniques to reduce pain and anxiety during labor. Also, counseling about breastfeeding and family planning after birth should be initiated during the prenatal period and reinforced during post partum care.

The majority of the women (37%) had most of their prenatal care visits in a district hospital or in the Tirana maternity hospital. A similar proportion (33%) used policlinics, especially in Tirana or in another city, for most of their prenatal care visits and 23% of pregnant women used health centers or health posts for their visits (data not shown). It seems that some proportion of women living in rural areas prefer to use health services located in Tirana or other urban areas instead of going to the nearest health center or health post for examinations and counseling. Only 7% of pregnant women sought prenatal care in private clinics, ranging from 13% in Tirana to 5% in rural areas.

To complete the picture of the quality of prenatal care, besides the utilization of services discussed above, the reproductive health survey included additional questions aimed at assessing information received and measurements performed during the prenatal visit; that is the adequacy of the content of prenatal care. Table 5.2 shows the percentage of pregnant women who received some information about specific educational topics during their prenatal care visit.

Only 60% of women who attended prenatal care clinics received some counseling about nutrition during pregnancy. The proportion of women who received counseling on breastfeeding and delivery is approximately the same, slightly over 58%. These three topics are, nevertheless, the most discussed during the prenatal visits among pregnant women in Albania. Other topics, like postnatal care, pregnancy complications, effects of smoking and alcohol, are remembered to have been discussed with a health professional by roughly half of the pregnant women. Contraception was less frequently mentioned as a counseling topic during prenatal care visits; less than 40% of women reported it.

Maternal characteristics that appear to be associated with lower levels of counseling for almost all the topics include rural residence, low levels of education (less than secondary education), and a low socioeconomic index. Other maternal characteristics related with poor counseling practices during prenatal care are age of the

mother, under 20 years old, and having two or more previous pregnancies. The number of prenatal visits was directly related to the proportion of women receiving information during their prenatal care visits.

In addition to counseling, the first prenatal visit should include a detailed medical history of the women and her family, including information about risk factors and genetic disorders, a detailed obstetrical history, a comprehensive physical examination, measurement of blood pressure, urine tests, basic blood tests, an ultrasound, and tests for various types of infection. Monitoring of mothers weight, blood pressure, and basic blood tests are extended during the follow up visits.

The proportion of women who have received examinations such as blood tests, urine tests and measurement of blood pressure is above 80% (Table 5.3). About three-fourths (77%) of women had an ultrasound examination during their prenatal care visit, while only 62% stated that they received a tetanus immunization. Only one in four pregnant women received iron supplements as part of their prenatal care.

Residing in a rural area, a low educational level and a low socioeconomic status remains associated with lower proportions of exposure to most of the selected procedures presented in table 5.3. On the other hand, having more than three prenatal care visits increases the chances of receiving an ultrasound examination. A private clinic, as a source of prenatal care, raised the odds for having an ultrasound exam and blood and urine tests but not for the measurement of blood pressure or other selected procedures.

Routine measurement of blood pressure is an essential component of health risk assessment during prenatal visits. Table 5.4 clearly shows that the majority of women who gave birth during the 1997–2002 period had routine measurements of their blood pressure during pregnancy (83.3%). Among them, more than one in ten has been told by a doctor that they have high blood pressure. The proportion of those hospitalized exclusively for this condition was very low (only 0.5%), while more than half of the pregnant women diagnosed with high blood pressure received treatment for it.

Although blood pressure was measured more frequently among more educated, higher socioeconomic status women and those living in urban areas, high blood pressure was found at a higher prevalence among rural women and women with lower educational and socioeconomic level. Treatment and hospitalization for high blood pressure among pregnant women followed the same profile. The number of prenatal visits steadily increases the identification rate of high blood pressure. As a result, the prevalence of high blood pressure among women, having more than 10 prenatal care visits, is almost three times higher compared to women who have attended only one to three prenatal visits.

Table 5.5 shows the prevalence of ultrasound exams during pregnancies, carried to term, between 1997 and 2002. Overall, about three in four pregnant women (77%) had at least one ultrasound exam. This prevalence is lower than that observed in the Czech Republic in 1993, similar to the more recent data of the Ukraine (78%) and Moldova (75%), but much higher than the prevalence observed in Romania (47%) and some Caucasus Countries; Georgia (54%) and Azerbaijan (26%).

Ultrasound exam rates in Albania, similarly to those observed elsewhere, are higher in urban areas, among better educated and higher socioeconomic status women, and among women having their first

child. Ultrasound examinations rates are positively associated with the number of prenatal visits.

Almost one in three women (30%) had their first ultrasound exam very early in their pregnancy (less than 14 weeks) while the relative majority of first exams occurred between 14 and 26 weeks of pregnancy (44%). The three characteristics mentioned before (urban residence, a high educational level and a high socioeconomic status) are associated to starting an ultrasound examination early among pregnant women. The utilization of a private clinic for prenatal care visits is another important factor that is positively associated to the starting ultrasound examinations early; around 43% of pregnant women using a private clinic as a source of prenatal care receive their first ultrasound exam within the first 14 weeks of pregnancy.

The reproductive health survey data does not allow differentiation between selected specific indications (e.g. confirmation of gestational age, assessment of fetal viability, fetal malformations, fetal growth, fetal presentation and multiple pregnancy, examination of the placenta, assessment of amniotic fluid) or for routine ultrasound screening, either during early pregnancy (less than 14 weeks) or in late pregnancy (after 27 weeks).

Almost one in three women had their first ultrasound exam very early in their pregnancy (less than 14 weeks) while the relative majority of first exams occurred between 14 and 26 weeks of pregnancy (43.8%). The three characteristics mentioned before (urban residence, a high educational level and a high socioeconomic status) are associated with having an ultrasound examination early among pregnant women. The utilization of a private clinic for prenatal care visits is another important factor that is positively associated with starting ultrasound examinations early; around 43% of pregnant women using a private clinic as a source of prenatal care receive their first ultrasound exam within the first 14 weeks of pregnancy.

Pregnancy complications

Table 5.6 presents pregnancy complications that required medical attention distributed by selected characteristics. Among all pregnancies brought to term since January 1997 and that have some prenatal care, almost one in four were reported to have some kind of pregnancy complication. The most frequently mentioned complication was the risk of preterm delivery (10%), followed by anemia related to pregnancy (7%), a weak cervix, water retention or edema, an urinary tract infection (around 6% each), followed by high blood pressure related to pregnancy, bleeding, and Rh isoimunisation. There are no significant differences among the different subgroups, based on background characteristics of the mothers.

Intrapartum care

In Albania all births are recommended to occur in medical facilities where adequately trained personnel can monitor the progress of labor and delivery. The reproductive health survey data demonstrates that 85% of births in the country are occurring in a district maternity hospital or in Tirana maternity (Table 5.7). Only around 8% of deliveries take place in "birth houses"; 13% in rural areas. Births delivered outside medical facilities or at home are rare but still represent a significant 6% of total births in the country.

The proportion of births occurring outside a hospital or in birth houses become even higher in several subgroups of the population reaching 22% in rural

areas, 19% among women with primary education, and almost 21% among those of low socioeconomic status. Giving birth at home is highly associated with inadequate prenatal care; women who had no prenatal care visits have a four times higher risk of delivering their baby at home, compared to those who have had some prenatal care visits. The rate of giving birth at home is more than 15% among this subgroup. Other characteristics which are likely to increase the risk of giving birth at home are age of the women (those 35–44 years have a rate of 11%) and birth order (10% for women who already have two children)

Delivery at a birth house is affected by the same factors as the delivery at home. The phenomenon of giving birth in a private clinic or hospital remains extremely rare in Albania; only among women of higher socioeconomic status does this proportion reach 2.5%.

Table 5.8 shows the time spent in a medical facility prior to delivery and the length of stay after delivery. The average time spent prior to delivery in the hospital was about 7 hours (shorter than the times observed in Romania and Georgia, but similar to that observed in Azerbaijan) (CDC and ORC MACRO, 2004). The average duration of labor generally ranges from 6 hours (for multiparous women) to 10 hours (for nulliparous women). Thus, many women, particularly those giving birth for the first time were admitted for delivery during or right after the onset of labor. The average time spent in the medical facilities prior to delivery was slightly shorter for women living in urban areas, and those of higher socioeconomic status, probably indicating better access to hospitals by women of these subgroups. The time spent in the hospital prior to delivery was longer for nulliparous women (almost 10 hours), those who deliver by C-section and those who gave birth to babies weighing less than 2500 g.

The majority of Albanian women (59%) stay in the medical premises less than three days after giving birth. Less than 20% stay in the hospital for more than four days and most of these are women who delivered by C-section. Only low birth weight babies and C-section deliveries are factors which highly increase the period of stay in the hospital after delivery. Other characteristics do not seem to be associated with period of stay in the hospital after delivery.

Table 5.9 shows the percentage of births delivered by C-section by selected characteristics. The Caesarian section (C-section) rate varies considerably among countries, from about 5% to more than 20% of all deliveries. The optimal rate is not known, but little improvement in birth outcomes has been demonstrated if the rate is higher that 7%. In addition to unequivocal obstetrical indications, a C-section is often performed in less clear situations (e.g. prolonged labor) and often if a previous C-section was performed, which is rarely an adequate indication by itself.

The reproductive health survey shows that although most births are delivered vaginally, in Albania, between 1997 and 2002, the rate of C-section deliveries was 13.4% and this figure is only slightly higher than those reported by several Eastern European countries and the Caucasus region, where similar surveys were carried out. The C-section rate in those countries ranges from 3% in Azerbaijan to 11% in Romania and 12% in Russian areas with surveys (CDC and ORC MACRO, 2004).

Women residing in Tirana were almost twice as likely to have a C-section delivery compared to women in rural areas, demonstrating that the bases of decision for a C-section may include other reasons apart from medical ones. The socioeconomic index was another factor seemingly associated with this type of delivery. Women of a

high socioeconomic status are more than twice as likely to have a C-section delivery. Factors which might increase the chances of having a C-section are the age of the mother (especially over 35 years), prolonged labor, pregnancy complications, low weight of the baby at birth, and to a lesser extent, being a first time mother.

The Albania RHS also included a question directed to women who gave birth during the study period on the most important reasons for a C-section delivery. The most frequent reasons given by them included mainly clinical factors like malpresentation of fetus (35%), prolonged labor or baby started to suffer (22%), and baby too big for vaginal delivery (7%). Having had a previous C-section is also mentioned quite frequently as a reason for the actual C-section (22%). There were only 6% of women that requested a C-section delivery. Although small numbers do not allow important conclusions to be made, this last reason is more frequently found in urban areas compared to rural areas (9% versus 2%).

Poor birth outcomes

Poor birth outcomes are considered stillbirths, preterm births (live births within 37 weeks of gestation) and infants weighting less than 2500 grams at birth (low birth rate-LBW). Selected poor birth outcomes in the five years preceding the survey are shown in table 5.10.

The incidence of low birth weight (LBW) for infants born alive during the study period was 4.6%. It is only slightly higher than the rate reported by a recent survey in Albania (UNICEF and INSTAT, 2000). Nevertheless, it is lower than the rates produced by similar studies in some Eastern European countries and the former Soviet Union. There are no clear trends in low birth rate among selected background categories of women apart from age and birth order; LBW rate was respectively 5.7% and 6.7% among women younger than 20 years and first time mothers, while only 1.5% among the 35–44 age group and 2.4% among women who have had three or more births.

The preterm birth rate is slightly lower than the LBW rate (3.6%) but the birth order characteristic has the same profile as the LBW rate. Prolonged labor increases more than twofold the risk of LBW (slightly less that of prematurity birth), and this fact is consistent with other findings in other similar studies.

Postnatal care

After the birth of the child, it is important to provide appropriate postnatal care for both the health of the mother and the child, which must include counseling about breastfeeding, nutrition, and family planning. The postnatal period is a critical time that allows the health care provider to evaluate the physical and psychological health of the new mother and her infant, to detect and treat possible postpartum complications and to provide the support needed to address any specific problems related to child care.

The Albania RHS provided information on the use of postnatal care and the content of postnatal counseling. As it is clearly demonstrated by Table 5.11, the percentage of women who attended a postpartum care visit within a specified time period is only a fraction of those who have been receiving some kind of prenatal care. Less than one in five women (19%), currently aged 15–44, who delivered live birth babies during the 1997–2002 period, had at least one postnatal care visit. Furthermore, only 36% had their first postnatal visit within the first week after the delivery. About 61% of women had their first visit within the first two weeks after the delivery. Urban residency, high

level of education and high socioeconomic category were the main factors influencing a higher rate of postpartum care. Those giving birth at the Tirana Maternity Hospital, first time mothers, and those with postpartum complications were also more inclined to use the postnatal care services than other women.

Information on whether women received a postpartum examination following their most recent live births was collected by the RHS or DHS surveys in five other countries in Eastern Europe and the Caucasus Region. There was a high variation in the proportion of women across these countries who received postpartum care, raging from 74% in Moldova down to 11% in Georgia. Except in Moldova, postpartum care coverage was always higher in urban areas than in rural areas. Coverage also tended to increase with education.

During the postnatal care visits more than 70% of the women received information on immunization, child care, nutrition, breastfeeding and breast care by a health professional (Table 5.12). Although less frequent, contraception counseling was also received by slightly more than half of the women (55%). The differences, regarding this topic, between selected categories are not very sharp but proportions are always lower among women living in the rural areas, with lower education, and a lower socioeconomic category.

The Albania RHS questionnaire included questions regarding healthcare for the baby after the delivery. Table 5.13 shows the proportion of live births followed by postnatal baby care, whether that care was received during a routine health exam or sickness, and the timing when the care happened. More than 85% of babies were seen by a health professional and there are very small differences between the various categories. In only a few cases were the visits made to examine a sick baby (8%). Almost everyone used baby health care as a part of a routine health exam; 45% of these visits took place during the first week after the delivery, while slightly more than 20% was done only after the second week of the baby's life.

The proportion of women who registered their newborns was more than 92%. Only women under the age of 20 seem to have lower than a 90% rate of registration. Between the other categories, there are no significant differences. Around 20% of mothers registered their babies during the first week after the delivery. This proportion increases to almost 70% after the second week (Table 5.14).

Smoking and drinking during pregnancy

Smoking and alcohol drinking during pregnancy does not seem to be a problem in Albania; very few women smoke before becoming pregnant (1.3%) and almost half of them stop smoking when they become pregnant. Among 3.1% of women drink some alcohol during pregnancy, the majority drinks less than once a week (data not shown).

Postpartum complications

Postpartum complications reported by women who gave birth in the five years prior to the survey are shown in table 5.15. Roughly one in four women experienced at least one postpartum complication. From Tirana City, postpartum complications were reported more frequently than from other areas of the country, rural or urban. This increase in frequency might be influenced by the presence of the University Hospital in Tirana (as the likelihood of being diagnosed with a pregnancy complication increases with the capacity of the services to diagnose them). Complications during

pregnancy increase two times the odds for having a postpartum complication. Higher postpartum complications rates for women under age of 20 are likely to be caused by a two times higher rate of experiencing a painful uterus among these women compared to those women of older ages.

Breastfeeding

Infant feeding practices influence the health of both the child and the mother. Breast milk is the most complete food an infant can receive during the first few months of life. Early initiation of breastfeeding – within an hour following birth- permits the newborn to benefit immediately from colostrum, which is highly nutritious and contains antibodies necessary to protect babies before they are able to produce their own appropriate immune system. Early initiation also takes advantage of the newborn's sucking reflex alertness immediately during postpartum. In addition, breastfeeding has been shown to contribute to longer birth intervals, improve maternal health by reducing postpartum bleeding, allowing an earlier return to pre-pregnancy weight, and reduce the risk of premenopausal breast cancer.

In early infancy, frequent breastfeeding, including night feeds, is important to ensure that the infant receives sufficient breast milk and is able to increase its weight. Current recommendations are that infants should be breastfeed 8–10 times every 24 hours, and even more frequently during the first month of life. On the other hand, frequent feeding also ensures that the mother maintains her ability to produce sufficient quantities of breast milk.

Optimal breast feeding for infants includes:

1. Initiation of breastfeeding within one hour of birth
2. Frequent on demand feeding (including night feeds)
3. Exclusive breastfeeding (defined as breast milk only and no other foods or liquids) until the infant is about 6 months of age

The Albania RHS included questions about breastfeeding patterns and duration for all children under 5 years of age. Table 5.16 shows the percentage of children ever breastfed and percent distribution of initiation of breastfeeding by selected categories. The overwhelming majority (93%) of all babies born during the 1997–2002 period were breastfed for at least a short period of time. This result is consistent with other recent surveys in the country. The rate is also similar to ever breastfeeding rates reported by the RHS or DHS studies in the East European countries and the former USSR countries. The rate for Albania is slightly higher than that of Armenia and Georgia (89%, 87%), almost equal to that of Romania (93%), and to some extent lower than those of Central Asian countries (95–97%)

The percentage of babies ever breastfed was not significantly influenced by background characteristics. Only babies having a low birth weight were slightly less likely to be breastfed than those with a birth weight of 2500 grams or more (79% versus 94%). The same was true for babies born with a cesarean section compared to those having a vaginal birth (88% versus 94%).

In the same table (5.16), in the right panel, time elapsed between delivery and initiation of breastfeeding is included. Only 15% of infants ever breastfed started to do so within the first hour of life. Most children (52%) began breastfeeding between two hours after birth and completion of the first day of life. Less than 10% started breastfeeding the second day and the remaining 23% after the second day of life.

There is a significant difference among those who started breastfeeding within the first hour of life between Tirana and other parts of the country (rural or urban). Women who give birth with a C-section are visibly inclined to start breastfeeding their babies late. To a lesser extent, the same is true for those giving birth to low birth weight babies.

An infant is "exclusively" breastfed when he or she receives only breast milk and "almost exclusively" breastfed or predominantly breastfed when he receives breast milk accompanied by water or other liquids (except other types of milk). Children who are exclusively or almost exclusively breastfed are considered to be "fully" breastfed (Labbok and Krasovec, 1990). These indicators are recommended by WHO to assess the adequacy of breastfeeding practices in a population and allow for comparisons with findings from other countries. The WHO recommendations state that "all infants should be fed exclusively on breast milk from birth to 4–6 months of age" and that some breastfeeding should be maintained until the child is at least 1 year old (WHO 1991).

The indicator used to estimate the duration of breastfeeding is the mean duration of three different types of breastfeeding; exclusive breastfeeding, full breastfeeding, and any breastfeeding. The results are presented in Table 5.17. The proportion of children under 5 years old still being breastfed at the time of the survey was calculated by the single months of age (0–59 months). Those proportions were summed together to calculate the mean duration of breastfeeding. This method is known as the "current status mean" method (WHO 1991). Duration of exclusive and full breastfeeding were calculated in the same way, where babies who did not yet initiate any other liquids or food were classified as exclusively breastfed and those who were either exclusively breastfed or started to take liquids but no other food were classified as fully breastfed.

The mean duration of any breastfeeding was 14.3 months and it does not seem to be highly influenced by background characteristics included in the analysis. Obviously the mean time duration of the two other indicators was much smaller, indicating that most of these 14 months infants were being fed only partially with their mother's milk. The mean duration of exclusive breastfeeding was 2.8 months and that of full breastfeeding was almost 5 months. The differences between selected categories remain small.

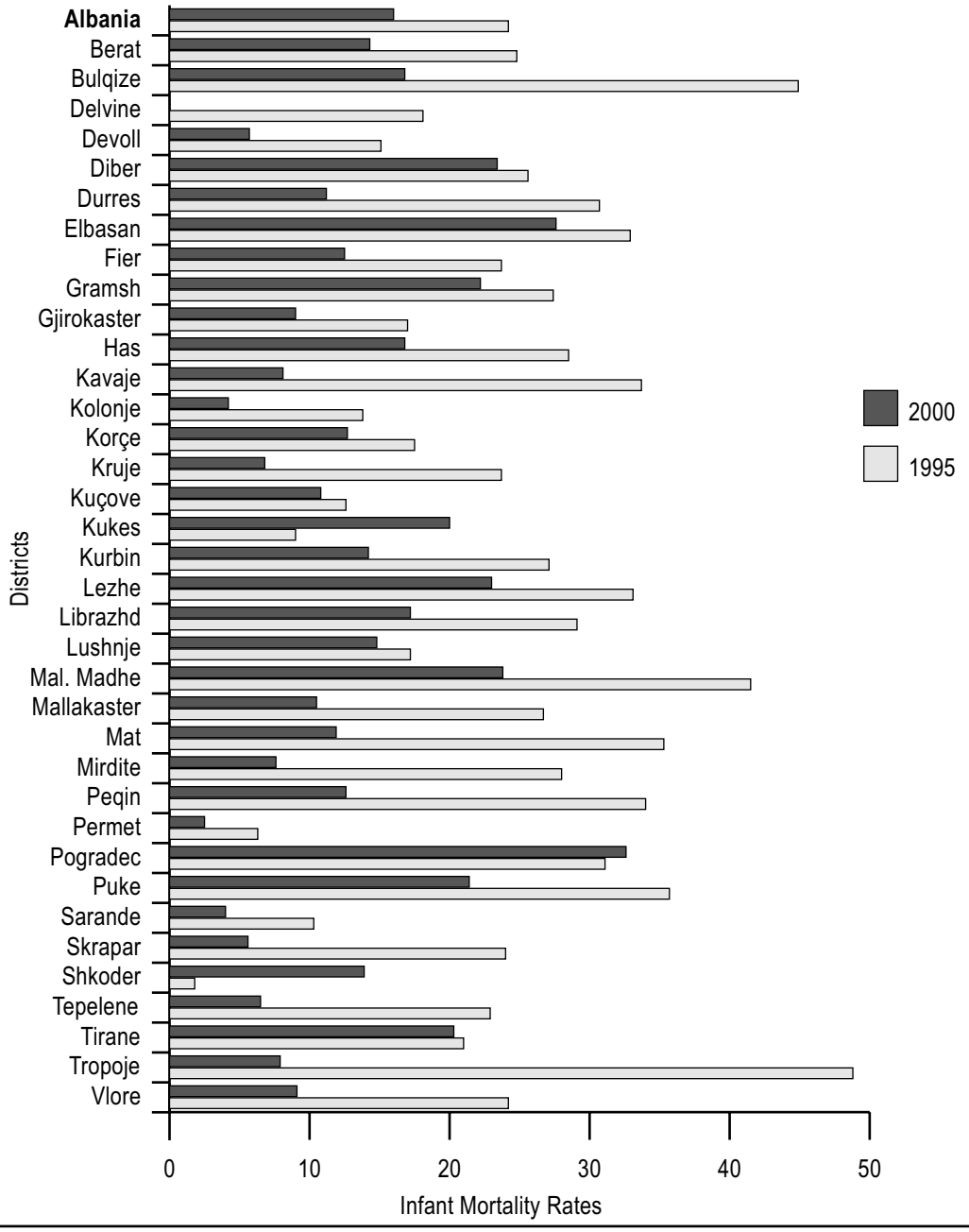
Infant and child mortality

Childhood mortality consists of deaths occurring among children from birth until the age of five. It can be broken down by an age classification: perinatal mortality, neonatal mortality, postneonatal mortality, infant mortality, child mortality (not to be confused with overall childhood mortality), and under five mortality. In this section perinatal mortality is not included. The age classifications used in this report are as follows:

- Neonatal mortality: the probability of dying between birth and less than 29 days
- Post neonatal mortality: the difference between infant and neonatal mortality rates
- Infant mortality: the probability of dying between birth and the exact age of one year
- Child mortality: the probability of dying between the exact ages of one and five years
- Under five mortality: the probability of dying between birth and the exact age of five years

Infant mortality is considered one of the crucial indicators for the health and social welfare of a country, as it synthesizes the quality of health care, nutrition, education and many other aspects of a society. Infant mortality for many years has been very high in Albania, ranked among the highest in the European Region. Despite a steady decrease from 45 per 1000 in 1990 to 16 per 1000 in 2000 in official reports, it remains far from the European Union standards. Official reports by the Ministry of Health of Albania demonstrate an infant mortality rate of 24.2/1,000 in 1995 and 16.0/1,000 in 2000. The official rates for 1995 and 2000 are presented by district in figure 5.3.

Figure 5.3
Infant Mortality Rates in Albaina by District, 1995–2000 (Ministry Of Health Data)

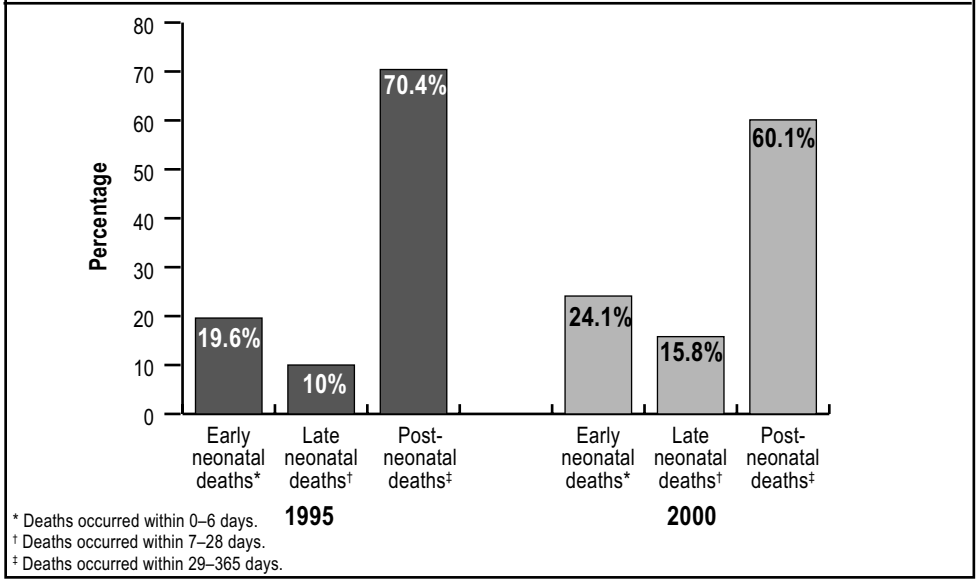


The survey questionnaire included a series of questions in the pregnancy history, which can help provided detailed information on infant and child mortality. For each live birth data are gathered on the date of the birth, sex of the child, survival status, and for children who have died, the age of when the death occurred. Respondents were asked to report pregnancy outcomes (e.g stillbirths and live births) according to international definitions. Accordingly, a live birth was defined as any infant, irrespective of the duration of the pregnancy, that breathes or shows any other signs of life after separation from the mother. Survey data on mortality levels among respondents' children were used to calculate the infant mortality (deaths before the first birthday per 1000) and child mortality (deaths between 12 and 59 completed months of age per 1000) rates. Infant mortality was further categorized into neonatal (0–28 days) and post-neonatal (29 days to 11 completed months) groups. Infant and child mortality rates were calculated by means of life table analysis.

Table 5.18 shows the survey estimates of infant and other childhood mortality rates distributed by selected categories. The infant mortality rate calculated for the period of August 1992 – July 2002 is 26.2 per 1000 and the under-5 mortality rate (children under five years), for the same period, is 31.9 per 1000. The survey IMR of 26.2 per 1000 for the 10 year period from 1992 to 2002 is 29% higher than the average official rate reported between 1995 and 2000. The MICS 2000 survey carried out two years prior to the Albania RHS has produced similar results; infant mortality was 28 per 1000 and child mortality was 33 per 1000 (UNICEF, 2000).

For this 10-year period of time, the estimated neonatal mortality rate is 11.9 per 1000 and the post-neonatal mortality result is 14.3 per 1000. In this type of survey and in vital statistics systems, underestimation of neonatal mortality tends to be greater than underestimation of child mortality at older ages. Some women do not always consider their births to be live births, especially when the death occurred in the first days of life. For this reason, the estimated 10 year neonatal and infant mortality rates should be considered minimum values. The RHS recorded 55% of infant deaths in the post-neonatal period, a similar result when compared to the 60% reported by the MOH in 2000 (see Figure 5.4).

Figure 5.4
Distribution of Neonatal and Post-Neonatal Deaths in Albania, 1995 and 2000 (Ministry of Health Data)



As shown in table 5.18, all indicators included in the table, with the exception of child mortality, neonatal mortality and post neonatal mortality are higher in rural areas. Accordingly, the infant mortality rate is around 40% higher in rural areas (30%) compared to urban areas. (21%). Only child mortality among 1–4 year olds seems quite similar in both areas. Another characteristic seemingly influencing the higher of the infant mortality rates, and to some extent under 5 mortality rates as well, is a low socioeconomic index. Nevertheless, one of the most strongly associated factors with infant mortality and under 5 mortality is education; among the lower education status group (not having finished secondary school), infant mortality is 2.3 times higher than in the more educated group. The difference is statistically significant. The ratio is almost as high when comparing child mortality among the two categories. Interestingly, the two later factors (socioeconomic index and education) do not seem to influence the risk of infants dying within the first month of life, a period of life, when other factors may be more important.

Infant mortality and post-neonatal mortality is higher for birth orders 3 or higher. Infants born after their mother had already two other children have higher rates. The infant mortality rate among them is almost 34 per 1000 while among the first born it is only 22.6 per 1000. The infant mortality rate estimate from the survey is 26.2/1000 with a 95% confidence interval of 21.8 to 30.6. The most strongly associated factor with infant mortality and child mortality in Albania seems to be birth spacing; children born within 24 months after their mothers had a previous birth have a three to four times higher risk of dying, either within the first year, or within the first five years of life, compared to children born after more than two years of time between the two births. Despite the small numbers, the difference is statistically significant.

Table 5.1
Prenatal Care by Pregnancy Trimester of First Visitand Number of Prenatal Visits, for Births in 1997–2002, by Selected Characteristics
(Percent Distribution)
Reproductive Health Survey: Albania 2002

	Trimester of First Prenatal Visit					Number of Prenatal Visits							
Characteristics	No visits	1st	2nd	3rd	Don't Know†	0	1–3	4–6	7–9	10+	Don't Know	Total	No. of Cases*
Total	**19.1**	**59.3**	**18.2**	**2.9**	**0.4**	**19.1**	**38.3**	**27.0**	**10.5**	**3.6**	**1.4**	**100.0**	**2,551**
Strata													
Metro Tirana	10.9	71.1	15.2	2.3	0.5	10.9	27.4	31.7	18.0	9.9	2.1	100.0	900
Other Urban	9.9	70.3	17.0	2.4	0.4	9.9	28.6	38.1	16.9	5.0	1.4	100.0	807
Other Rural	26.0	50.6	19.7	3.3	0.4	26.0	46.1	20.0	5.3	1.3	1.3	100.0	844
Residence													
Urban	9.0	72.0	16.3	2.4	0.4	9.0	27.2	37.0	18.2	7.0	1.7	100.0	1,522
Rural	26.0	50.6	19.6	3.3	0.4	26.0	46.0	20.1	5.3	1.3	1.2	100.0	1,029
Age Group at Birth													
< 20	15.1	53.9	28.0	2.8	0.2	15.1	42.6	31.2	7.1	2.5	1.4	100.0	196
20–24	18.4	62.1	16.2	2.8	0.3	18.4	41.2	24.0	12.1	3.1	1.1	100.0	867
25–34	19.2	59.4	17.9	3.0	0.5	19.2	36.9	27.8	10.5	4.1	1.5	100.0	1,350
35–44	28.2	50.4	18.8	2.6	0.0	28.2	27.3	30.7	6.5	4.4	3.0	100.0	138
Education Level													
Primary or Less	25.0	50.9	21.0	2.7	0.4	25.0	43.6	21.1	6.9	1.9	1.4	100.0	1,228
Secondary Incomplete	10.7	68.6	16.1	4.7	0.0	10.7	29.3	38.3	13.6	4.9	3.3	100.0	179
Secondary Complete	12.3	69.8	14.2	3.2	0.5	12.3	33.8	33.0	14.0	5.6	1.3	100.0	880
Post-Secondary	7.4	75.4	14.9	2.1	0.2	7.4	22.8	38.9	22.3	8.0	0.6	100.0	264
Socioeconomic Index													
Low	26.4	49.4	20.1	3.5	0.6	26.4	43.7	21.3	4.8	1.9	1.7	100.0	1,020
Medium	13.0	66.4	18.0	2.4	0.3	13.0	36.3	30.7	14.1	4.8	1.1	100.0	1,222
High	10.4	78.5	8.7	2.2	0.2	10.4	17.3	39.5	24.2	7.2	1.4	100.0	309
Birth Order													
First	12.4	64.3	19.5	3.2	0.6	12.4	39.2	29.3	13.2	4.1	1.7	100.0	963
Second	19.0	61.6	16.7	2.4	0.4	19.0	38.1	27.7	9.7	4.3	1.2	100.0	964
Third or More	28.9	49.2	18.5	3.1	0.3	28.9	37.4	22.6	7.7	2.1	1.4	100.0	624
Baby Weight at Birth													
< 2500 Grams	18.6	55.4	21.1	2.3	2.5	18.6	36.6	26.7	9.1	6.6	2.3	100.0	123
≥ 2500 Grams	19.1	59.9	17.8	2.9	0.3	19.1	38.2	27.1	10.6	3.5	1.4	100.0	2,414
Don't Know	**	**	**	**	**	**	**	**	**	**	**	**	14

* Data are missing for 5 live births in the last 5 years

** Percentages are not shown when base is less than 25 cases

† Women who did attend prenatal care but did not know in which trimester they began prenatal care

Table 5.2
Percentage Counseled on Specific Topics During Prenatal Care Visits for Births in 1997–2002 by Selected Characteristics, among Women with Any Prenatal Care
Reproductive Health Survey: Albania 2002

Characteristics	Nutrition	Breast Feeding	Delivery	Postnatal Care	Pregnancy Complications	Effects of Smoking	Effects of Alcohol	Contra-ception	No. of Cases
Total	**60.0**	**58.7**	**58.2**	**52.8**	**50.8**	**53.3**	**53.3**	**37.9**	**2,152**
Strata									
Metro Tirana	69.9	69.9	67.5	64.5	63.6	60.0	60.8	46.4	805
Other Urban	66.7	66.2	65.5	58.8	57.4	62.0	61.2	41.2	725
Other Rural	52.6	50.5	50.8	45.4	42.7	45.8	46.1	33.2	622
Residence									
Urban	68.6	68.4	67.0	61.7	60.3	62.4	62.1	44.0	1,394
Rural	52.7	50.5	50.8	45.3	42.8	45.6	45.9	32.8	758
Age Group at Birth									
< 20	56.5	56.3	58.9	49.8	49.1	49.2	48.4	33.7	168
20–24	61.8	60.0	57.4	54.3	51.9	55.4	55.7	38.6	733
25–34	58.2	57.1	58.0	51.6	49.7	51.5	51.3	36.9	1,141
35–44	70.2	68.7	64.6	59.5	56.5	63.5	65.1	49.6	110
Education Level									
Primary or Less	51.8	50.1	50.6	44.9	43.0	45.2	45.1	31.4	943
Secondary Incomplete	61.6	62.5	60.5	57.4	53.8	56.9	57.6	40.8	163
Secondary Complete	68.2	66.7	66.1	60.0	58.8	60.5	60.6	43.8	797
Post-Secondary	79.7	79.6	75.0	72.5	67.8	74.9	74.9	54.6	249
Socioeconomic Index									
Low	50.7	49.7	49.9	45.2	42.1	43.9	44.2	29.9	785
Medium	64.3	62.6	62.4	56.2	54.5	57.9	58.1	42.7	1,080
High	81.6	81.0	76.3	71.6	73.6	74.1	72.1	50.7	287
Birth Order									
First	63.6	62.6	61.8	57.6	53.5	57.5	57.3	39.1	858
Second	61.4	60.0	59.8	54.3	52.9	54.4	54.6	41.1	818
Third or More	51.5	49.7	49.6	42.1	42.8	44.2	44.4	31.0	476
Number of Prenatal Visits									
1–3	54.3	51.5	52.7	48.0	47.1	48.3	48.1	39.2	872
4–6	63.4	65.0	63.0	55.4	52.9	57.7	57.9	35.9	767
7–9	67.8	66.0	62.8	57.6	54.0	58.7	58.7	35.1	334
10+	71.7	66.0	65.4	61.9	59.6	59.6	60.1	44.3	137
Don t Know	60.4	60.1	65.5	71.6	64.6	48.7	49.8	45.8	42
Place of Prenatal Care									
District/Tirana Maternity/ Hospital	55.0	54.1	53.7	50.2	47.9	50.3	50.3	36.8	682
Policlinic	64.7	64.1	64.2	57.6	56.3	57.1	57.4	38.9	841
Rural/Urban Health Center	66.0	64.9	62.9	60.1	57.7	59.0	58.9	48.0	249
Health Post	62.3	58.5	52.1	44.4	42.5	51.9	52.4	29.5	195
Private Office/Clinic/ Hospital	52.1	50.1	54.6	49.9	46.1	46.6	45.0	40.9	173
At Home/Other	**	**	**	**	**	**	**	**	12

** Percentages are not shown when base is less than 25 cases

Table 5.3
Percentage Experiencing Selected Procedures During Prenatal Care Visits for Births in 1997–2002 by Selected Characteristics, among Women with Any Prenatal Care
Reproductive Health Survey: Albania 2002

Characteristics	Blood Sample Taken	Urine Sample Taken	Blood Pressure Measured	Had Ultrasound Exam	Tetanus Inmunization	Iron Supplements	No. of Cases
Total	**85.4**	**85.0**	**83.3**	**76.5**	**61.6**	**25.1**	**2,152**
Strata							
Metro Tirana	91.6	92.0	88.2	88.4	48.2	32.4	805
Other Urban	92.7	93.3	89.1	82.4	67.1	35.9	725
Other Rural	78.9	77.7	78.2	69.1	62.3	16.0	622
Residence							
Urban	93.1	93.7	89.0	84.7	60.9	36.1	1,394
Rural	79.0	77.8	78.6	69.6	62.1	15.8	758
Age Group at Birth							
< 20	90.0	91.4	80.1	74.9	55.0	21.5	168
20–24	85.5	85.3	81.6	75.2	62.8	26.0	733
25–34	83.8	83.0	84.3	77.8	61.8	24.4	1,141
35–44	91.8	91.8	90.6	75.1	62.4	31.4	110
Education Level							
Primary or Less	80.4	80.5	79.8	71.1	59.9	16.3	943
Secondary Incomplete	87.7	81.2	80.6	81.0	68.0	35.1	163
Secondary Complete	89.9	90.0	87.2	80.5	61.7	32.9	797
Post-Secondary	98.5	98.5	93.8	92.2	66.3	43.0	249
Socioeconomic Index							
Low	79.7	79.7	80.1	65.4	58.2	11.5	785
Medium	88.5	87.8	84.9	83.2	65.1	31.9	1,080
High	96.2	96.6	90.3	93.8	58.4	54.1	287
Birth Order							
First	88.3	87.9	83.9	80.3	59.9	29.0	858
Second	87.9	87.3	83.8	74.5	64.6	24.5	818
Third or More	76.6	76.7	81.5	72.7	59.9	18.9	476
Number of Prenatal Visits							
1–3	77.3	77.0	78.0	67.6	60.8	15.3	872
4–6	91.6	90.9	85.7	81.8	62.8	29.8	767
7–9	96.7	96.3	92.3	90.1	59.9	40.6	334
10+	95.9	95.9	94.0	91.0	63.8	49.4	137
Don t Know	78.5	79.6	87.2	76.8	65.3	22.3	42
Place of Prenatal Care							
District/Tirana Maternity/Hospital	87.7	88.2	82.6	79.4	61.4	23.8	682
Policlinic	88.0	88.0	86.8	78.4	59.8	26.8	841
Rural/Urban Health Center	91.0	87.4	86.1	76.5	64.6	25.1	249
Health Post	66.2	65.1	75.3	54.1	70.4	10.4	195
Private Office/Clinic/Hospital	91.4	90.6	80.4	90.7	53.3	47.8	173
At Home/Other	**	**	**	**	**	**	12

** Percentages are not shown when base is less than 25 cases

Table 5.4
Percentage with Routine Measurement of Blood Pressure (BP) During Pregnancy, Reported High Blood Pressure (HBP) During Pregnancy, and Hospitalization Rate for HBP, for Births in 1997–2002, among Women with Any Prenatal Care
Reproductive Health Survey: Albania 2002

Characteristics	Measurement of Blood Pressure	Told High Blood Pressure	Treatment HBP	Pregnancies Hospitalized for HBP (Exclusive)*	Pregnancies Hospitalized for HBP (Not Exclusive)*	No. of Cases
Total	**83.3**	**11.4**	**51.0**	**0.5**	**2.3**	**2,152**
Strata						
Metro Tirana	88.2	13.7	36.2	0.2	2.0	805
Other Urban	89.1	9.9	50.3	0.3	2.1	725
Other Rural	78.2	11.6	57.7	0.7	2.5	622
Residence						
Urban	89.0	10.9	54.3	0.3	2.1	1,394
Rural	78.6	11.8	44.3	0.7	2.4	758
Age Group at Birth						
< 20	80.1	11.9	48.2	0.0	3.0	168
20–24	81.6	7.9	42.7	0.1	1.8	733
25–34	84.3	12.9	52.3	0.8	1.9	1,141
35–44	90.6	17.6	67.6	1.4	7.8	110
Education Level						
Primary or Less	79.8	13.5	53.1	0.5	2.8	943
Secondary Incomplete	80.6	9.9	55.7	0.3	2.4	163
Secondary Complete	87.2	9.2	52.5	0.6	1.6	797
Post-Secondary	93.8	8.7	23.4	0.2	1.2	249
Socioeconomic Index						
Low	80.1	12.5	50.0	0.8	2.4	785
Medium	84.9	10.8	53.1	0.3	2.1	1,080
High	90.3	9.7	44.7	0.0	2.5	287
Birth Order						
First	83.9	11.7	47.5	0.5	2.4	858
Second	83.8	8.7	45.4	0.4	1.7	818
Third or More	81.5	15.0	61.1	0.6	3.0	476
Number of Prenatal Visits						
1–3	78.0	8.6	40.8	0.1	1.4	872
4–6	85.7	10.7	45.9	0.7	1.8	767
7–9	92.3	17.3	61.1	0.6	4.9	334
10+	94.0	24.5	71.9	3.2	5.6	137
Don t Know	87.2	9.8	87.6	1.0	6.5	42
Place of Prenatal Care						
District/Tirana Maternity/Hospital	82.6	12.9	63.7	0.9	3.4	682
Policlinic	86.8	9.5	45.2	0.2	1.9	841
Rural/Urban Health Center	86.1	7.9	44.7	0.2	1.5	249
Health Post	75.3	10.8	53.9	0.6	0.6	195
Private Office/Clinic/Hospital	80.4	14.7	26.7	0.0	2.4	173
At Home/Other	**	**	**	**	**	12

* Exclusive - hospitalized only for high blood pressure; non-exclusive - hospitalized with high blood pressure as only one of conditions.

** Percentages are not shown when base is less than 25 cases

Table 5.5
Use of Ultrasound Exams During Pregnancy and Time of First Ultrasound Exam, By Selected Characteristics, for Births in 1997–2002, among Women with Any Prenatal Care
Reproductive Health Survey: Albania 2002

	Had Ultrasound Exam		Time of First Ultrasound Exam (Percent Distribution)					
Characteristics	%	No. of Cases	< 14 weeks	14–26 weeks	27 +	Dk/Dr	Total	No. of Cases
Total	**76.5**	**2,152**	**29.6**	**43.8**	**26.0**	**0.6**	**100.0**	**1,736**
Strata								
Metro Tirana	88.4	805	35.5	34.6	29.0	0.9	100.0	712
Other Urban	82.4	725	30.6	47.1	21.7	0.6	100.0	599
Other Rural	69.1	622	26.5	45.1	28.0	0.4	100.0	425
Residence								
Urban	84.7	1,394	32.7	42.3	24.3	0.7	100.0	1,204
Rural	69.6	758	26.5	45.4	27.7	0.4	100.0	532
Age Group at Birth								
< 20	74.9	168	23.5	45.8	30.4	0.3	100.0	132
20–24	75.2	733	33.1	42.9	23.5	0.4	100.0	586
25–34	77.8	1,141	28.9	43.6	26.7	0.8	100.0	928
35–44	75.1	110	24.2	48.7	27.1	0.0	100.0	90
Education Level								
Primary or Less	71.1	943	25.6	47.0	26.9	0.4	100.0	698
Secondary Incomplete	81.0	163	26.2	50.2	22.1	1.6	100.0	136
Secondary Complete	80.5	797	34.4	39.1	25.9	0.6	100.0	667
Post-Secondary	92.2	249	36.2	38.6	24.7	0.5	100.0	235
Socioeconomic Index								
Low	65.4	785	23.6	45.8	30.2	0.4	100.0	544
Medium	83.2	1,080	31.1	44.2	24.0	0.7	100.0	923
High	93.8	287	43.2	35.0	21.4	0.5	100.0	269
Birth Order								
First	80.3	858	31.2	41.5	27.1	0.2	100.0	719
Second	74.5	818	26.3	46.9	25.8	1.0	100.0	657
Third or More	72.7	476	31.6	43.7	24.1	0.7	100.0	360
Number of Prenatal Visits								
1–3	67.6	872	22.1	48.6	29.1	0.2	100.0	615
4–6	81.8	767	29.7	47.8	22.2	0.4	100.0	651
7–9	90.1	334	45.0	30.2	23.3	1.6	100.0	307
10+	91.0	137	43.5	22.9	31.9	1.8	100.0	128
Don t Know	76.8	42	33.1	31.0	34.5	1.4	100.0	35
Place of Prenatal Care								
District/Tirana Maternity/Hospital	79.4	682	34.3	43.1	22.4	0.2	100.0	567
Policlinic	78.4	841	24.4	47.0	27.7	0.9	100.0	693
Rural/Urban Health Center	76.5	249	29.0	44.7	26.4	0.0	100.0	196
Health Post	54.1	195	18.1	52.0	28.2	1.7	100.0	109
Private Office/Clinic/Hospital	90.7	173	42.7	28.9	28.1	0.3	100.0	164
At Home/Other	**	**	**	**	**	**	**	7

** Percentages are not shown when base is less than 25 cases

Table 5.6
Percentage of Pregnancy Complications that Required Medical Attention, by Selected Characteristics, for Births in 1997–2002, among Women with Any Prenatal Care
Reproductive Health Survey: Albania 2002

Characteristics	Any Pregnancy Complication	Risk of Preterm Delivery	Anemia Related to Preg.	Weak Cervix	Water Retention or Edema	Urinary Tract Infection	High BP Related to Preg.	Bleeding During First 6 Mth	Bleeding at 6 Mth or More	Rh Isoimmu-nization	Other	No. of Cases
Total	**24.2**	**9.9**	**7.1**	**6.4**	**6.3**	**6.1**	**5.3**	**4.2**	**1.5**	**1.5**	**1.8**	**2,152**
Strata												
Metro Tirana	22.1	7.8	6.9	6.3	5.6	6.4	5.2	5.4	1.0	1.8	2.2	805
Other Urban	22.4	8.6	7.9	5.6	4.8	5.2	4.7	4.3	1.5	0.6	2.3	725
Other Rural	26.0	11.3	6.7	6.9	7.4	6.5	5.7	3.7	1.6	1.9	1.4	622
Residence												
Urban	22.6	8.3	7.6	5.9	5.1	5.6	4.9	4.8	1.3	1.1	2.3	1,394
Rural	25.5	11.1	6.6	6.8	7.3	6.4	5.6	3.7	1.6	1.8	1.4	758
Age Group at Birth												
< 20	24.0	11.0	10.8	6.9	7.2	8.5	5.1	3.2	2.8	0.8	2.6	168
20–24	24.8	10.4	7.1	7.8	5.9	6.4	3.5	4.8	0.5	1.5	1.9	733
25–34	23.9	9.2	6.3	5.3	5.9	5.0	5.9	3.9	1.6	1.7	1.6	1,141
35–44	23.6	10.6	7.9	7.1	10.8	9.1	10.8	4.5	4.0	0.0	2.2	110
Education Level												
Primary or Less	23.9	9.6	6.9	7.4	6.1	6.2	6.1	3.8	1.7	1.8	1.2	943
Secondary Incomplete	28.0	11.3	7.4	3.5	12.4	6.1	6.1	2.9	1.6	0.3	3.5	163
Secondary Complete	23.6	10.2	7.1	5.0	6.0	6.2	4.5	4.8	1.4	1.3	1.9	797
Post-Secondary	24.8	8.6	8.5	8.2	3.7	4.7	1.9	5.8	0.5	0.9	4.8	249
Socioeconomic Index												
Low	24.2	8.9	7.7	6.4	7.3	5.4	5.2	3.5	1.6	1.6	1.8	785
Medium	23.7	10.2	5.8	5.8	5.7	6.4	5.4	3.8	1.5	1.3	1.8	1,080
High	26.7	12.7	11.4	9.6	5.0	7.5	4.9	9.6	0.2	1.6	2.1	287
Birth Order												
First	26.6	12.6	8.3	7.4	6.4	6.9	5.3	6.0	0.8	1.8	1.5	858
Second	22.1	7.3	6.1	5.9	5.8	5.3	3.8	3.0	1.2	1.7	2.5	818
Third or More	23.0	8.8	6.4	5.5	6.9	5.7	7.5	2.8	3.0	0.6	1.6	476

Table 5.7
Place of Delivery for Births in 1996–2001 by Selected Characteristics
(Percent Distribution)
Reproductive Health Survey: Albania 2002

	Place of Delivery						
Characteristics	District Maternity Hospital	Tirana Maternity	Birth House/ Health Center	Private Clinic/ Hospital	At Home	Total	No. of Cases
Total	**70.9**	**14.3**	**8.2**	**0.6**	**6.0**	**100.0**	**2,551**
Strata							
Metro Tirana	16.6	78.0	2.0	0.9	2.5	100.0	900
Other Urban	92.8	2.9	2.2	1.3	0.8	100.0	807
Other Rural	73.8	3.6	12.9	0.2	9.6	100.0	844
Residence							
Urban	70.2	25.6	2.0	1.2	1.0	100.0	1,522
Rural	71.3	6.6	12.5	0.2	9.4	100.0	1,029
Age Group at Birth							
< 20	73.5	15.3	4.5	0.0	6.8	100.0	196
20–24	72.2	14.2	8.2	0.7	4.8	100.0	867
25–34	70.2	14.3	8.7	0.7	6.1	100.0	1,350
35–44	64.9	13.8	10.1	0.3	11.0	100.0	138
Education Level							
Primary or Less	70.3	10.1	11.0	0.4	8.3	100.0	1,228
Secondary Incomplete	74.5	16.0	5.6	0.0	3.9	100.0	179
Secondary Complete	70.9	19.8	4.9	1.1	3.2	100.0	880
Post-Secondary	71.9	24.4	1.9	1.3	0.4	100.0	264
Socioeconomic Index							
Low	69.7	8.9	10.6	0.2	10.6	100.0	1,020
Medium	74.4	16.0	6.7	0.7	2.1	100.0	1,222
High	56.9	37.3	2.5	2.5	0.8	100.0	309
Birth Order							
First	73.8	17.8	5.4	0.7	2.4	100.0	963
Second	68.5	14.7	9.4	0.9	6.6	100.0	964
Third or More	69.8	8.8	10.8	0.2	10.4	100.0	624
Trimester of First Prenatal Visit							
No Visits	65.6	6.8	12.2	0.3	15.1	100.0	399
1st	70.6	18.0	7.1	0.8	3.5	100.0	1,634
2nd	75.3	10.7	8.4	0.6	5.1	100.0	438
3rd	85.1	10.0	2.4	0.0	2.6	100.0	69
Don't Know	**	**	**	**	**	**	11

** Percentages are not shown when base is less than 25 cases

Table 5.8
Average Time Between Admission and Delivery and Percent Distribution of Number of Nights Spent in a Medical Facility, for Births in 1997–2002
Reproductive Health Survey: Albania 2002

Characteristics	Average Time Between Admission and Delivery (Hours)	Nights Spent in a Medical Facility Between Delivery and Discharge (Percent Distribution)					Total	No. of Cases
		0–2	3–4	5	6–7	8 or More		
Total	**7.2**	**59.0**	**21.8**	**4.0**	**7.0**	**8.2**	**100.0**	**2,444**
Strata								
Metro Tirana	6.8	60.4	19.2	6.0	6.9	7.5	100.0	876
Other Urban	6.0	56.9	22.0	4.8	8.5	7.8	100.0	800
Other Rural	8.0	59.8	22.4	3.0	6.2	8.6	100.0	768
Residence								
Urban	6.2	57.3	21.7	5.3	8.2	7.5	100.0	1,503
Rural	7.9	60.3	21.8	3.1	6.2	8.6	100.0	941
Age Group at Birth								
< 20	9.8	57.8	24.4	3.4	8.6	5.8	100.0	185
20–24	7.9	59.4	20.9	3.7	7.6	8.4	100.0	835
25–34	6.3	59.7	21.8	4.2	6.2	8.1	100.0	1,292
35–44	7.2	52.5	23.4	5.1	8.0	11.0	100.0	132
Education Level								
Primary or Less	7.7	58.8	23.1	3.2	7.3	7.6	100.0	1,150
Secondary Incomplete	5.5	59.2	20.6	7.3	4.2	8.8	100.0	174
Secondary Complete	7.0	58.9	20.2	4.7	6.8	9.4	100.0	858
Post-Secondary	5.4	61.3	19.1	4.3	8.8	6.4	100.0	262
Socioeconomic Index								
Low	7.9	59.6	21.0	3.7	7.7	8.0	100.0	939
Medium	6.7	59.4	22.6	3.5	5.8	8.7	100.0	1,199
High	5.9	53.3	21.3	8.6	10.5	6.3	100.0	306
Birth Order								
First	9.9	53.5	20.9	4.2	10.8	10.7	100.0	948
Second	5.3	60.7	24.3	4.2	4.9	6.0	100.0	919
Third or More	5.7	65.3	19.8	3.6	4.1	7.2	100.0	577
Baby Weight at Birth								
< 2500 Grams	12.6	21.6	16.2	3.7	15.8	42.7	100.0	116
≥ 2500 Grams	6.9	60.8	22.1	4.0	6.6	6.5	100.0	2,320
Dk/Dr	**	**	**	**	**	**	**	8
Type of Delivery								
Vaginal	6.3	67.2	22.7	2.8	4.0	3.2	100.0	2,075
Cesarean Section	13.4	5.9	15.8	11.8	26.4	40.1	100.0	369
Pregnancy Complications								
Yes	9.6	45.2	24.2	6.3	11.7	12.6	100.0	495
No	6.6	62.7	21.1	3.4	5.8	7.0	100.0	1,949

** Percentages are not shown when base is less than 25 cases

Table 5.9
Percentage of Cesarean Deliveries by Selected Characteristics, for Births in 1997–2002, among Women Currently Aged 15–44
Reproductive Health Survey: Albania 2002

Characteristics	Cesarean Deliveries	No. of Cases
Total	**13.4**	**2,444**
Strata		
Metro Tirana	19.2	876
Other Urban	14.4	800
Other Rural	11.2	768
Residence		
Urban	16.0	1,503
Rural	11.4	941
Age Group at Birth		
< 20	8.6	185
20–24	11.7	835
25–34	14.0	1,292
35–44	25.3	132
Education Level		
Primary or Less	12.0	1,150
Secondary Incomplete	12.1	174
Secondary Complete	15.3	858
Post-Secondary	16.7	262
Socioeconomic Index		
Low	11.0	939
Medium	14.0	1,199
High	22.7	306
Birth Order		
First	16.4	948
Second	12.2	919
Third or More	10.1	577
Pregnancy Complications		
Yes	19.0	495
No	11.9	1,949
Baby Weight at Birth		
< 2500 Grams	36.0	116
≥ 2500 Grams	12.3	2,320
Don't know	**	8
Prolonged Labor		
No	4.4	2,094
Yes	21.4	65
No Labor	98.9	233
Don't know	16.8	52

** Percentages are not shown when base is less than 25 cases

Table 5.10
Percentage of Poor Birth Outcomes by Selected Characteristics, for Births in 1997–2002, Among Women Currently Aged 15–44
Reproductive Health Survey: Albania 2002

Characteristics	Low Birth Weight < 2,500 grams	Preterm Birth	No. of Cases
Total	**4.6**	**3.6**	**2,551**
Strata			
Metro Tirana	5.3	4.3	900
Other Urban	4.1	3.6	807
Other Rural	4.7	3.4	844
Residence			
Urban	4.4	4.0	1,522
Rural	4.7	3.3	1,029
Age Group at Birth			
< 20	5.7	2.5	196
20–24	5.6	3.9	867
25–34	4.1	3.7	1,350
35–44	1.5	2.5	138
Education Level			
Primary or Less	5.4	3.1	1,228
Secondary Incomplete	3.8	1.5	179
Secondary Complete	3.2	4.7	880
Post-Secondary	5.0	4.6	264
Socioeconomic Index			
Low	5.5	3.3	1,020
Medium	3.4	3.5	1,222
High	6.6	5.8	309
Prenatal Care Visits			
Yes	4.6	3.7	2,152
No	4.5	2.9	399
Birth Order			
First	6.7	5.1	963
Second	4.0	2.8	964
Third or More	2.4	2.3	624
Pregnancy Complications			
Yes	8.9	5.5	498
No	3.5	3.1	2,053
Prolonged Labor			
No	3.9	3.5	2,195
Yes	9.5	5.8	70
No Labor	9.0	3.8	233
Don't know	10.5	0.8	53

Table 5.11
Percentage Who Attended Postpartum Care Visit within Specified Time Periods by Selected Characteristics, for Births in 1997–2002, among Women Currently Aged 15–44
Reproductive Health Survey: Albania 2002

	Postpartum Care		Time betwen Delivery and First Postpartum Visit (Percent Distribution of Weeks)					
Characteristics	%	No. of Cases	< 1	1–2	> 2	Don't Remember	Total	No. of Cases
Total	**18.7**	**2,551**	**36.0**	**24.9**	**34.3**	**4.8**	**100.0**	**549**
Strata								
Metro Tirana	26.9	900	25.2	35.7	36.8	2.3	100.0	243
Other Urban	21.9	807	33.3	27.1	36.5	3.1	100.0	179
Other Rural	14.8	844	43.1	18.2	31.5	7.2	100.0	127
Residence								
Urban	23.8	1,522	30.0	29.5	37.9	2.7	100.0	384
Rural	15.1	1,029	42.5	20.0	30.5	7.1	100.0	165
Age Group at Birth								
< 20	15.7	196	45.5	26.8	27.7	0.0	100.0	39
20–24	18.7	867	38.9	19.3	40.6	1.2	100.0	174
25–34	19.2	1,350	31.4	29.7	31.2	7.6	100.0	303
35–44	18.3	138	46.4	13.8	32.2	7.5	100.0	33
Education Level								
Primary or Less	16.0	1,228	44.2	19.0	34.0	2.8	100.0	215
Secondary Incomplete	21.2	179	41.8	30.0	28.2	0.0	100.0	45
Secondary Complete	20.6	880	27.7	29.3	34.1	8.8	100.0	203
Post-Secondary	30.2	264	20.5	34.4	40.0	5.0	100.0	86
Socioeconomic Index								
Low	13.9	1,020	39.7	27.2	28.5	4.6	100.0	158
Medium	21.3	1,222	37.8	23.3	34.2	4.7	100.0	292
High	31.8	309	18.9	25.1	50.3	5.7	100.0	99
Birth Order								
First	20.5	963	34.9	22.9	36.2	6.0	100.0	230
Second	18.6	964	36.6	25.2	35.2	3.1	100.0	205
Third or More	16.2	624	37.1	28.1	29.5	5.2	100.0	114
Place of Delivery								
District Maternity Hospital	17.8	1,527	40.0	22.2	34.7	3.0	100.0	294
Tirana Maternity	30.2	744	24.8	31.9	33.5	9.7	100.0	216
Private Clinic/Hospital	**	**	**	**	**	**	**	9
Birth House/Health Center	9.7	154	38.6	26.3	23.7	11.4	100.0	19
At Home	8.9	107	**	**	**	**	**	11
Postpartum Complications								
Any Complications	26.8	676	27.5	27.7	41.9	2.9	100.0	214
No Complications	16.0	1,875	40.7	23.4	30.1	5.9	100.0	335

** Percentages are not shown when base is less than 25 cases

Table 5.12
Percentage of Women with Information Received During Postpartum Care by Selected Characteristics, for Births in 1997–2002
Reproductive Health Survey: Albania 2002

Characteristics	Inmunization	Child Care	Nutrition	Breastfeeding	Breast Care	Contraception	No. of Cases
Total	**76.1**	**74.7**	**72.9**	**72.8**	**71.9**	**55.0**	**549**
Strata							
Metro Tirana	82.6	79.1	80.2	76.4	78.0	60.1	243
Other Urban	79.7	79.6	80.2	77.5	78.6	60.6	179
Other Rural	70.4	68.9	64.0	67.5	63.9	48.3	127
Residence							
Urban	82.0	81.2	81.5	78.8	80.0	62.9	384
Rural	69.8	67.8	63.7	66.3	63.1	46.5	165
Age Group at Birth							
< 20	81.1	72.6	76.9	68.1	70.2	52.4	39
20–24	76.2	74.5	74.4	70.5	72.6	55.7	174
25–34	75.4	75.2	71.4	75.1	71.4	53.6	303
35–44	75.6	74.1	72.7	72.7	74.1	65.8	33
Education Level							
Primary or Less	67.3	65.1	65.5	63.3	64.4	47.4	215
Secondary Incomplete	81.2	81.2	81.2	78.8	78.8	69.9	45
Secondary Complete	84.7	82.8	76.7	81.1	75.7	59.1	203
Post-Secondary	86.4	88.7	88.6	86.2	88.7	66.4	86
Socioeconomic Index							
Low	64.7	65.9	65.1	64.7	65.2	49.6	158
Medium	82.1	79.3	76.2	76.7	74.3	58.6	292
High	83.2	80.4	81.2	79.2	80.4	55.2	99
Birth Order							
First	81.9	79.3	75.1	76.6	73.3	54.2	230
Second	77.2	76.7	75.3	74.8	75.7	60.1	205
Third or More	64.0	63.6	65.4	62.9	63.6	48.9	114
Place of Delivery							
District Maternity Hospital	74.1	71.7	72.5	70.5	71.0	53.4	294
Tirana Maternity	83.8	82.5	74.8	78.2	72.3	57.5	216
Private Clinic/Hospital	**	**	**	**	**	**	9
Birth House/Health Center	84.8	98.1	85.2	96.2	98.1	66.5	19
At Home	**	**	**	**	**	**	11
Postpartum Complications							
Any Complications	74.8	73.3	75.1	69.6	70.9	52.8	214
No Complications	76.9	75.5	71.7	74.6	72.4	56.2	335

** Percentages are not shown when base is less than 25 cases

Table 5.13
Time Between Delivery and First Baby Clinic Visit by Selected Characteristics, for Births in 1997–2002
Reproductive Health Survey: Albania 2002

	Postnatal Baby Clinic Visit		Sick or Well Baby Clinic Visit		Time Between Delivery and First Postnatal Well Baby Clinic Visit (Percent Distribution of Months)					
Characteristics	%	No. of Cases	Health Exam for Sickness	Routine Health Exam	< 1	1–2	> 2	Don't Remember	Total	No. of Cases
Total	**85.8**	**2551**	**8.4**	**91.6**	**45.0**	**32.7**	**20.8**	**1.5**	**100.0**	**2,245**
Strata										
Metro Tirana	91.4	900	4.9	95.1	42.7	38.2	18.3	0.8	100.0	823
Other Urban	88.5	807	8.0	92.0	44.8	31.0	23.0	1.2	100.0	720
Other Rural	83.0	844	9.6	90.4	45.8	32.0	20.4	1.9	100.0	702
Residence										
Urban	89.9	1522	7.2	92.8	44.1	33.5	21.5	1.0	100.0	1,390
Rural	83.0	1029	9.3	90.7	45.6	32.1	20.4	1.9	100.0	855
Age Group at Birth										
< 20	86.5	196	14.0	86.0	43.5	26.0	29.0	1.5	100.0	170
20–24	83.3	867	8.3	91.7	41.2	34.1	23.9	0.9	100.0	743
25–34	86.5	1350	7.4	92.6	47.3	32.1	18.5	2.1	100.0	1,200
35–44	94.1	138	8.3	91.7	48.5	38.6	12.6	0.3	100.0	132
Education Level										
Primary or Less	82.8	1228	9.4	90.6	42.9	33.6	22.0	1.5	100.0	1,032
Secondary Incomplete	85.7	179	8.1	91.9	52.8	30.9	12.1	4.2	100.0	159
Secondary Complete	90.1	880	6.4	93.6	45.7	32.1	21.0	1.2	100.0	807
Post-Secondary	92.8	264	8.9	91.1	50.7	29.2	19.6	0.5	100.0	247
Socioeconomic Index										
Low	82.8	1020	10.0	90.0	45.0	32.7	20.4	1.9	100.0	853
Medium	88.5	1222	7.5	92.5	43.8	33.0	21.8	1.4	100.0	1,107
High	88.8	309	4.2	95.8	52.3	30.2	17.4	.	100.0	285
Birth Order										
First	85.1	963	10.2	89.8	41.2	32.9	24.2	1.8	100.0	839
Second	85.6	964	6.8	93.2	46.5	31.6	19.7	2.1	100.0	856
Third or More	87.2	624	7.9	92.1	48.4	33.6	17.6	0.3	100.0	550
Place of Delivery										
District Maternity Hospital	85.6	1527	9.9	90.1	42.3	31.7	24.0	2.0	100.0	1,328
Tirana Maternity	91.8	744	5.1	94.9	41.0	40.4	18.5	0.2	100.0	685
Private Clinic/Hospital	**	**	**	**	**	**	**	**	**	16
Birth House/Health Center	89.6	154	3.4	96.6	61.0	31.6	6.5	0.8	100.0	136
At Home	70.1	107	5.0	95.0	70.7	22.5	6.5	0.4	100.0	80

** Percentages are not shown when base is less than 25 cases

Table 5.14
Percentage of Babies With Birth Certificates Issued and Time Between Delivery and Certificate Issued for Births in 1997–2002
Reproductive Health Survey: Albania 2002

Characteristics	% With Birth Certificate		Interval Betwen Delivery and Birth Certificate (Percent Distribution of Weeks)						
	Yes	No. of Cases	< 1	1–2	3–4	> 4	Don't Remember	Total	No. of Cases
Total	**92.6**	**2,551**	**19.9**	**49.4**	**16.9**	**10.8**	**3.0**	**100.0**	**2,361**
Strata									
Metro Tirana	90.7	900	15.5	47.9	21.7	12.3	2.6	100.0	817
Other Urban	94.5	807	22.1	50.8	14.0	9.6	3.6	100.0	767
Other Rural	92.2	844	19.9	49.1	17.2	11.1	2.8	100.0	777
Residence									
Urban	93.3	1,522	20.8	49.7	15.9	10.2	3.3	100.0	1,414
Rural	92.1	1,029	19.2	49.3	17.5	11.2	2.8	100.0	947
Age Group at Birth									
< 20	88.8	196	19.5	47.0	12.5	15.6	5.3	100.0	166
20–24	92.5	867	20.3	46.9	16.6	12.8	3.3	100.0	798
25–34	93.0	1,350	20.4	49.9	18.0	9.3	2.4	100.0	1,263
35–44	95.5	138	14.5	62.3	15.3	5.5	2.4	100.0	134
Education Level									
Primary or Less	91.5	1,228	19.7	49.8	16.0	12.2	2.2	100.0	1,114
Secondary Incomplete	88.5	179	22.4	35.4	18.5	16.7	7.0	100.0	161
Secondary Complete	95.3	880	19.6	51.3	17.5	7.9	3.6	100.0	835
Post-Secondary	94.9	264	20.0	50.7	19.6	6.6	3.1	100.0	251
Socioeconomic Index									
Low	93.2	1,020	18.8	50.3	17.7	10.5	2.8	100.0	939
Medium	92.2	1,222	21.0	49.4	15.8	10.4	3.4	100.0	1,134
High	91.3	309	20.4	43.9	18.7	15.2	1.8	100.0	288
Birth Order									
First	90.1	963	**	**	**	**	**	**	**
Second	93.6	964	21.8	48.7	17.8	9.0	2.8	100.0	908
Third or More	94.9	624	19.7	52.5	16.2	8.8	2.8	100.0	591
Place of Delivery									
District Maternity Hospital	92.8	1,527	**	**	**	**	**	**	**
Tirana Maternity	91.3	744	11.9	48.5	23.8	10.5	5.2	100.0	676
Private Clinic/Hospital	**	**	**	**	**	**	**	**	17
Birth House/Health Center	94.4	154	17.4	58.5	15.1	7.5	1.5	100.0	145
At Home	91.3	107	22.2	42.1	15.3	16.7	3.8	100.0	95

** Percentages are not shown when base is less than 25 cases

Table 5.15
Percentage of Women Reporting Postpartum Complications, by Selected Characteristics, for Births in 1997–2002
Reproductive Health Survey: Albania 2002

Characteristics	Post Partum Complication	Painful Uterus	Painful Urination	Bad Smelling Vaginal charge	Severe Bleeding	High Fever	Breast Infection	Infection of Surgical Wound	Faint/ Coma	Other	No. of Cases
Total	**24.8**	**15.9**	**7.4**	**6.5**	**5.9**	**4.8**	**4.3**	**4.2**	**2.9**	**0.5**	**2,551**
Strata											
Metro Tirana	32.0	19.1	8.2	8.1	8.6	6.5	5.9	6.6	2.8	0.9	900
Other Urban	23.5	14.0	6.7	5.6	5.5	4.1	4.3	3.6	2.7	0.3	807
Other Rural	23.7	16.1	7.5	6.5	5.3	4.7	3.9	3.9	3.1	0.5	844
Residence											
Urban	26.2	15.4	7.2	6.1	6.5	5.1	4.8	4.6	2.9	0.5	1,522
Rural	23.9	16.3	7.5	6.7	5.4	4.6	4.0	3.9	3.0	0.5	1,029
Age Group at Birth											
< 20	31.5	22.2	9.3	7.5	5.5	6.0	3.3	3.9	3.3	1.3	196
20–24	23.9	14.9	7.9	6.7	5.9	4.8	4.4	5.3	3.1	0.5	867
25–34	25.0	15.9	6.7	6.3	5.8	4.6	4.3	3.5	2.6	0.3	1,350
35–44	19.1	12.6	6.4	5.2	6.8	5.0	5.3	4.8	4.6	2.0	138
Education Level											
Primary or Less	24.8	15.8	7.8	6.7	6.6	5.4	4.5	4.2	3.2	0.6	1,228
Secondary Incomplete	27.7	20.6	5.1	5.6	3.0	3.9	4.8	1.0	3.0	0.7	179
Secondary Complete	24.1	15.9	7.4	6.8	4.7	3.3	3.8	4.9	2.6	0.3	880
Post-Secondary	25.4	12.6	5.9	4.4	7.9	6.9	4.7	4.4	2.1	1.2	264
Socioeconomic Index											
Low	23.7	15.6	7.3	6.7	5.8	5.1	4.5	3.9	3.1	0.6	1,020
Medium	25.3	16.1	7.0	6.3	5.9	4.3	4.0	4.1	2.4	0.4	1,222
High	29.7	16.7	9.6	6.7	6.0	5.8	5.1	6.8	5.2	1.1	309
Birth Order											
First	26.0	16.6	10.1	5.4	5.9	5.4	4.4	6.0	3.1	0.7	963
Second	23.3	14.5	5.7	6.8	4.4	3.9	4.7	3.3	2.3	0.2	964
Third or More	25.2	16.8	5.6	7.6	7.7	5.1	3.7	2.9	3.6	0.8	624
Pregnancy Complications											
Yes	40.1	26.3	13.5	13.4	11.9	10.1	5.9	9.8	5.0	0.7	505
No	20.9	13.3	5.8	4.7	4.3	3.5	3.9	2.8	2.4	0.5	2,046
Prolonged Labor											
No	23.1	15.3	7.2	6.2	5.8	4.1	3.7	3.3	2.5	0.5	2,195
Yes	43.6	26.8	10.1	14.1	6.2	8.8	11.4	16.0	9.5	0.5	70
No Labor	35.8	18.5	7.9	6.5	6.0	9.6	7.0	9.1	6.2	0.6	233
Dk/Dr	31.2	16.6	6.9	6.6	6.1	9.0	10.3	6.0	0.8	0.0	53

Table 5.16
Percent of Children Ever Breastfed and Percent Distribution of Initiation of Breastfeeding, by Selected Characteristics, for Births in 1997–2002
Reproductive Health Survey: Albania 2002

Characteristics	Children Ever Breastfed		Initiation of Breastfeeding After Birth (Percent Distribution of Hours)						
	%	No. of Cases	1 Hour or Less	2–23	24–47	48 Hours or More	Unknown	Total	No. of Cases
Total	**93.2**	**2,551**	**15.4**	**51.8**	**8.8**	**23.2**	**0.9**	**100.0**	**2,381**
Strata									
Metro Tirana	93.5	900	22.5	47.0	7.0	22.5	1.0	100.0	839
Other Urban	92.9	807	14.7	50.9	9.2	24.8	0.5	100.0	753
Other Rural	93.3	844	13.9	53.5	9.0	22.6	1.0	100.0	789
Residence									
Urban	93.0	1,522	17.3	49.2	8.4	24.4	0.7	100.0	1,415
Rural	93.4	1,029	14.1	53.5	9.0	22.4	1.0	100.0	966
Age Group at Birth									
< 20	92.3	196	16.3	50.4	7.7	23.5	2.0	100.0	179
20–24	93.5	867	14.1	53.7	8.3	22.9	0.9	100.0	810
25–34	93.0	1,350	16.8	51.2	9.2	22.1	0.6	100.0	1,260
35–44	95.0	138	9.1	47.6	9.6	32.9	0.9	100.0	132
Education Level									
Primary or Less	93.3	1,228	14.4	54.6	7.2	23.0	0.8	100.0	1,143
Secondary Incomplete	90.7	179	18.4	49.0	6.0	25.6	1.0	100.0	166
Secondary Complete	93.1	880	16.1	48.1	12.6	22.1	1.1	100.0	820
Post-Secondary	95.6	264	17.2	47.2	7.7	27.6	0.2	100.0	252
Socioeconomic Index									
Low	93.9	1,020	15.1	52.6	8.2	22.7	1.4	100.0	957
Medium	93.0	1,222	15.0	52.1	9.1	23.3	0.5	100.0	1,142
High	90.8	309	19.1	44.6	10.6	25.7	0.0	100.0	282
Birth Order									
First	93.4	963	14.8	48.3	10.2	25.5	1.2	100.0	896
Second	93.5	964	17.2	53.6	7.6	21.0	0.6	100.0	902
Third or More	92.7	624	13.7	54.4	8.3	22.7	0.8	100.0	583
Type of Delivery									
Vaginal	93.9	2,182	16.8	55.6	7.9	18.8	0.9	100.0	2,054
Cesarean Section	88.3	369	4.7	23.4	15.4	55.7	0.8	100.0	327
Baby Weight at Birth									
< 2500 Grams	79.0	123	11.7	44.0	11.1	32.8	0.4	100.0	100
≥ 2500 Grams	94.0	2,414	15.6	52.1	8.7	22.7	0.9	100.0	2,270
Don't know	**	**	**	**	**	**	**	**	11

** Percentages are not shown when base is less than 25 cases

Table 5.17
Mean Duration of Breastfeeding in Months, by Type of Breastfeeding and Selected Characteristics, for Births in 1997–2002
Reproductive Health Survey: Albania, 2002

Characteristics	Exclusive Breastfeeding	Full Breastfeeding	Any Breastfeeding
Total	**2.8**	**4.9**	**14.3**
Strata			
Metro Tirana	2.7	4.8	15.2
Other Urban	2.5	4.9	13.8
Other Rural	2.9	4.9	14.6
Residence			
Urban	2.4	4.7	14.1
Rural	3.0	5.0	14.7
Age Group at Birth			
< 25	2.7	5.1	13.9
25–44	3.1	4.8	14.9
Education Level			
Secondary Incomplete or Less	3.0	5.2	14.8
Secondary Complete or More	2.0	4.1	13.4
Socioeconomic Index			
Low	2.9	5.2	15.7
Medium/High	2.7	4.8	13.2
Birth Order			
First	3.1	4.9	13.5
Second or More	2.6	4.8	14.8
Type of Delivery			
Vaginal	2.7	5.2	14.3
Cesarean Section	**	**	**
Initiation of Brestfeeding			
1 Hour or Less	2.4	4.4	16.1
2–23 Hours	3.2	5.8	15.8
24 or More	3.1	5.7	14.4
Unknown	**	**	**
Baby Weight at Birth			
< 2500 Grams	**	**	**
≥ 2500 Grams	3.0	5.2	14.7
Don't know	**	**	**

**Percentages are not shown when base is less than 25 cases

Table 5.18
Infant and Child Mortality Rates (Infant and Child Deaths per 1,000 Live Births) by Selected Characterisitcs, for Children Born August 1992–July 2002
Reproductive Health Survey: Albania 2002

Characteristics	Infant Mortality			Child Mortality (1–4 years)	Under-5 Mortality	No. of Births
	Total	Neonatal	Postneonatal			
Total	**26.2**	**11.9**	**14.3**	**5.8**	**31.9**	**4,823**
Residence						
Urban	21.7	10.3	11.5	6.2	27.8	2,881
Rural	29.3	13.0	16.3	5.5	34.7	1,942
Age Group at Birth						
< 25	23.6	13.0	10.6	6.0	29.4	2,066
25–44	28.2	11.1	17.1	5.7	33.7	2,757
Education Level						
Secondary Incomplete or Less	33.4	12.8	20.6	7.4	40.6	2,576
Secondary Complete or Post-Secondary	14.7	10.4	4.3	3.3	18.0	2,247
Socioeconomic Index						
Low	31.4	11.6	19.8	5.7	36.9	1,949
Medium/High	21.4	12.1	9.2	5.9	27.2	2,874
Birth Order						
1	22.6	10.3	12.3	6.1	28.6	1,874
2	23.1	13.6	9.5	5.3	28.2	1,800
3+	33.9	11.9	22.0	5.9	39.7	1,148
Birth Interval *						
First Births	21.7	10.6	11.1	6.0	27.6	1,746
< 24	63.8	31.4	32.4	7.2	70.5	841
24 +	14.5	5.3	9.2	4.6	19.0	2,208

* Excludes 28 cases with birth interval undefined